FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047191

Facility Name: Alden Springs

Address: 207 East Army Trail Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: (630) 523-5783 **Fax #** (630) 523-5787

HFS ID Number:

Date of Initial License for Current Owners: 9/25/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)		0	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,456			5,456	13
14	TOTALS	5,456			5,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.42%

D. How many bed-hold days during this year were paid by the Department?
364 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started 10/13/06

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	55,715	7,553	1,100	64,368	1,004	65,372	117	65,489			1
2	Food Purchase		49,673		49,673	(3,019)	46,654	(13,555)	33,099			2
3	Housekeeping	18,126	6,475		24,601		24,601	668	25,269			3
4	Laundry		4,072		4,072		4,072		4,072			4
5	Heat and Other Utilities			22,911	22,911		22,911	212	23,123			5
6	Maintenance	3,092		42,855	45,947		45,947	(1,239)	44,708			6
7	Other (specify):* Related party							918	918			7
8	TOTAL General Services	76,933	67,773	66,866	211,572	(2,015)	209,557	(12,879)	196,678			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	341,536	19,590	1,130	362,256	2,622	364,878	5,892	370,770			10
10a	Therapy					6,166	6,166	(4,739)	1,427			10a
11	Activities			22,402	22,402		22,402		22,402			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							846	846			15
16	TOTAL Health Care and Programs	341,536	19,590	26,532	387,658	8,788	396,446	1,999	398,445			16
	C. General Administration											
17	Administrative	15,969			15,969		15,969	11,158	27,127			17
18	Directors Fees											18
19	Professional Services			91,286	91,286	(1,804)	89,482	(81,449)	8,033			19
20	Dues, Fees, Subscriptions & Promotions			10,750	10,750		10,750	(9,097)	1,653			20
21	Clerical & General Office Expenses	37,415	2,545	7,864	47,824		47,824	32,949	80,773			21
22	Employee Benefits & Payroll Taxes			54,225	54,225	1,197	55,422		55,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			985	985		985	245	1,230			24
25	Other Admin. Staff Transportation			2,644	2,644		2,644	1,536	4,180			25
26	Insurance-Prop.Liab.Malpractice			16,799	16,799		16,799	1,846	18,645			26
27	Other (specify):* Related party			448	448		448	5,947	6,395			27
28	TOTAL General Administration	53,384	2,545	185,001	240,930	(607)	240,323	(36,865)	203,458			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	471,853	89,908	278,399	840,160	6,166	846,326	(47,745)	798,581			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.

Facility Name & ID Number Alden Springs #0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,074	4,074		4,074	64,851	68,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,550	7,550		7,550	86,572	94,122			32
33	Real Estate Taxes			28,201	28,201	(28,201)		28,711	28,711			33
34	Rent-Facility & Grounds			132,459	132,459	28,201	160,660	(160,660)				34
35	Rent-Equipment & Vehicles			5,258	5,258		5,258	3,941	9,199			35
36	Other (specify):*											36
37	**TOTAL Ownership**			177,542	177,542		177,542	23,415	200,957			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,794	6,165	15,959	(6,166)	9,793	(3,292)	6,501			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,452	65,452		65,452		65,452			42
43	Other (specify):*			270,151	270,151		270,151		270,151			43
44	**TOTAL Special Cost Centers**		9,794	341,768	351,562	(6,166)	345,396	(3,292)	342,104			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	471,853	99,702	797,709	1,369,264		1,369,264	(27,622)	1,341,642			45

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

Alden Springs IDPH Facility ID Number: #0042010
Reclassifications on Pgs 3 & 4 - Column 5
Report Period Beginning: 1/1/2010
Report Period Ending: 12/31/2010

From Line	To Line	Amount	Description
2		(3,019.00)	Employee Meals
	22	3,019.00	Employee Meals
22		(1,822.00)	Uniforms
	10	818.00	Uniforms
	1	1,004.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
33		(28,201.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	28,201.00	Rent - Real Estate Tax on associated landowner (Pg 6)
Others, if any:			
19		(1,803.84)	Clinical Coordinators (Pathway Billing)
	10	1,803.84	Clinical Coordinators (Pathway Billing)
DD Providers Only:			
39		(6,166.00)	PT, OT, & ST CPT Therapy Costs
	10A	6,166.00	PT, OT, & ST CPT Therapy Costs
Net		-	

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(811)	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	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(448)	27		24
25	Fund Raising, Advertising and Promotional	(1,935)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,390)		$	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)	(14,943)	Various	34
35	Other- Attach Schedule	(9,289)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,232)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (27,622)		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						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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Alden Springs

ID# 0047191

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utilities	$ (92)	5	1
2	Intercompany Interest Not allowed (GL#7031)	(7,350)	32	2
3	Misc. Income-Other (W/C Refund)	(7)	21	3
4	Miscellaneous Income - Garnishment Processing	(2)	21	4
5	Back out 30% (for 2010) of PAC fees	(265)	20	5
6	Elim. Landowner Bank Charges	(10)	19	6
7	Elim. Landowner Tax Penalty	(1,243)	32	7
8	Elim Deprec on Pg 12 < $2,500 items	(42)	30	8
9	Elim Deprec on Pg 13 < $2,500 items	2,596	30	9
10	Expense Pg 13 items< $2,500 Curr Yr	(3,205)	6	10
11	Expense Pg 13 items< $2,500	320	6	11
12	Misc.Depreciation adjustment	43	30	12
13	Elim PAC fees from Dues & Subscription	(6)	20	13
14	Deming Adjustment	(150)	24	14
15	Add back Prior year adjustment-Emp. Recruitment	124	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,289)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs # 0047191 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	496	(379)	0	0	0	0	0	0	0	117	1
2	Food Purchase	0	0	0	(13,555)	0	0	0	0	0	0	0	(13,555)	2
3	Housekeeping	0	0	668	0	0	0	0	0	0	0	0	668	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(92)	0	304	0	0	0	0	0	0	0	0	212	5
6	Maintenance	(3,696)	0	2,598	0	0	0	(141)	0	0	0	0	(1,239)	6
7	Other (specify):*	0	0	679	239	0	0	0	0	0	0	0	918	7
8	**TOTAL General Services**	(3,788)	0	4,745	(13,695)	0	0	(141)	0	0	0	0	(12,879)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,669	28	195	0	0	0	0	0	0	5,892	10
10a	Therapy	0	0	0	0	0	(4,739)	0	0	0	0	0	(4,739)	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	846	0	0	0	0	0	0	0	0	846	15
16	**TOTAL Health Care and Programs**	0	0	6,515	28	195	(4,739)	0	0	0	0	0	1,999	16
	C. General Administration													
17	Administrative	0	0	11,158	0	0	0	0	0	0	0	0	11,158	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10)	10	(81,449)	0	0	0	0	0	0	0	0	(81,449)	19
20	Fees, Subscriptions & Promotions	(2,232)	250	(7,115)	0	0	0	0	0	0	0	0	(9,097)	20
21	Clerical & General Office Expenses	(9)	0	28,407	4,274	277	0	0	0	0	0	0	32,949	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	(150)	0	395	0	0	0	0	0	0	0	0	245	24
25	Other Admin. Staff Transportation	0	0	1,536	0	0	0	0	0	0	0	0	1,536	25
26	Insurance-Prop.Liab.Malpractice	0	1,830	16	0	0	0	0	0	0	0	0	1,846	26
27	Other (specify):*	(448)	0	5,834	560	1	0	0	0	0	0	0	5,947	27
28	**TOTAL General Administration**	(2,849)	2,090	(41,218)	4,834	278	0	0	0	0	0	0	(36,865)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,637)	2,090	(29,958)	(8,833)	473	(4,739)	(141)	0	0	0	0	(47,745)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden Springs** **#** **0047191** **Report Period Beginning:** **1/1/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	2,597	60,705	1,549	0	0	0	0	0	0	0	0	64,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,639)	89,054	6,148	0	9	0	0	0	0	0	0	86,572	32
33	Real Estate Taxes	0	28,201	507	0	3	0	0	0	0	0	0	28,711	33
34	Rent-Facility & Grounds	0	(160,660)	0	0	0	0	0	0	0	0	0	(160,660)	34
35	Rent-Equipment & Vehicles	0	0	3,941	0	0	0	0	0	0	0	0	3,941	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,042)	17,300	12,145	0	12	0	0	0	0	0	0	23,415	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	(3,537)	245	0	0	0	0	0	0	(3,292)	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	(3,537)	245	0	0	0	0	0	0	(3,292)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,679)	19,390	(17,813)	(12,370)	730	(4,739)	(141)	0	0	0	0	(27,622)	45

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 Pg 6K		See Pg 6K		

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 160,660	Alden Trails II, LLC	0.00%	$	$ (160,660)	1
2	V	19	Bank Charges		Alden Trails II, LLC		10	10	2
3	V	20	Dues & Subscriptions		Alden Trails II, LLC		250	250	3
4	V	33	Real Estate Tax Expense		Alden Trails II, LLC		28,201	28,201	4
5	V	26	General Insurance Expense		Alden Trails II, LLC		1,830	1,830	5
6	V	32	Interest - Harris		Alden Trails II, LLC		87,811	87,811	6
7	V	30	Depreciation		Alden Trails II, LLC		60,705	60,705	7
8	V	32	Tax Penalty		Alden Trails II, LLC		1,243	1,243	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 160,660			$ 180,050	$ * 19,390	14

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Alden Management Services, Inc.	0.00%	$ 304	$ 304	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		395	395	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,536	1,536	17
18	V	26	Insurance		Alden Management Services, Inc.		16	16	18
19	V	20	Dues/Subscriptions	7,248	Alden Management Services, Inc.		133	(7,115)	19
20	V	30	Depreciation		Alden Management Services, Inc.		1,549	1,549	20
21	V	33	Real Estate Tax		Alden Management Services, Inc.		507	507	21
22	V	35	Rent-Equip/Vehic		Alden Management Services, Inc.		3,941	3,941	22
23	V	32	Interest		Alden Management Services, Inc.		6,148	6,148	23
24	V	1	Dietary Salary		Alden Management Services, Inc.		496	496	24
25	V	3	Housekeeping Salary		Alden Management Services, Inc.		668	668	25
26	V	7	Employee Benef-Gen'l Servs		Alden Management Services, Inc.		679	679	26
27	V	10	Nurs/Med Rec Salary		Alden Management Services, Inc.		5,669	5,669	27
28	V	15	Employee Benef-Health Care		Alden Management Services, Inc.		846	846	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		11,158	11,158	29
30	V	27	Employee Benef-Administrative		Alden Management Services, Inc.		5,834	5,834	30
31	V	19	Professional Fees	86,737	Alden Management Services, Inc.		5,288	(81,449)	31
32	V	21	Gen'l & Admin		Alden Management Services, Inc.		28,407	28,407	32
33	V	6	Repair & Mainten.	1,840	Alden Management Services, Inc.		4,438	2,598	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 95,825			$ 78,012	$ * (17,813)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Diet. Consultant	$ 1,100	Prism Health Care Services, Inc.	0.00%	$ 156	$ (944)	15
16	V	1	Dietary Salary		Prism Health Care Services, Inc.		565	565	16
17	V	2	Tube Feeding	19,213	Prism Health Care Services, Inc.		5,658	(13,555)	17
18	V	10	Equipment Rental	360	Prism Health Care Services, Inc.		388	28	18
19	V	39	Supplies	7,823	Prism Health Care Services, Inc.		4,286	(3,537)	19
20	V	21	Salary G & A		Prism Health Care Services, Inc.		3,000	3,000	20
21	V	27	Employee Benefits		Prism Health Care Services, Inc.		560	560	21
22	V	7	Employee Benefits		Prism Health Care Services, Inc.		239	239	22
23	V	21	G & A		Prism Health Care Services, Inc.		1,274	1,274	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			$ 28,496			$ 16,126	$ * (12,370)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 1,231	Forum Extended Care Services II, Inc.	0.00%	$ 1,733	$ 502	15
16	V	39	IV	152	Forum Extended Care Services II, Inc.		19	(133)	16
17	V	39	Wound Care	588	Forum Extended Care Services II, Inc.		464	(124)	17
18	V	10	House Stock	858	Forum Extended Care Services II, Inc.		789	(69)	18
19	V	10	Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		648	264	19
20	V	27	Employee Vaccinations	95	Forum Extended Care Services II, Inc.		75	(20)	20
21	V	27	Employee Benefit: G & A		Forum Extended Care Services II, Inc.		21	21	21
22	V	21	Salary: G & A		Forum Extended Care Services II, Inc.		170	170	22
23	V	21	General & Administrative		Forum Extended Care Services II, Inc.		107	107	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		9	9	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		3	3	25
26	V	30	Depreciation		Forum Extended Care Services II, Inc.				26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,308			$ 4,038	$ * 730	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Therapy	$ 6,165	Community Physical Therapy & Associates, Ltd.	0.00%	$ 1,426	$ (4,739)	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			$ 6,165			$ 1,426	$ * (4,739)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$ 11,527	Alden Bennett Construction Company, Inc.	0.00%	$ 11,386	$ (141)	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			$ 11,527			$ 11,386	$ * (141)	39

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

Alden Springs | Alden Springs | Provider No. 0047191 | Report Period Beginning: 1/1/10 | Ending: 12/31/10

RELATED NURSING HOMES	
Name	City
Heather Health Care Center, Inc.	Harvey
Alden-Long Grove Rehabilitation and Health Care Center, Inc.	Long Grove
Alden-Lincoln Park Rehabilitation and Health Care Center, Inc.	Chicago
Alden-Northmoor Rehabilitation and Health Care Center, Inc.	Chicago
Alden-Lakeland Rehabilitation and Health Care Center, Inc.	Chicago
Alden of Old Town East, Inc.	Bloomingdale
Alden Terrace of McHenry Rehabilitation and Health Care Center, Inc.	McHenry
Alden - Wentworth Rehabilitation and Health Care Center, Inc.	Chicago
Alden Estates of Naperville, Inc.	Naperville
Alden - Valley Ridge Rehabilitation and Health Care Center, Inc.	Bloomingdale
Alden Village Health Facility for Children and Young Adults, Inc.	Bloomingdale
Alden - Orland Park Rehabilitation and Health Care Center, Inc.	Orland Park
Alden - Princeton Rehabilitation and Health Care Center, Inc.	Chicago
Alden of Old Town West, Inc.	Bloomingdale
Alden - Town Manor Rehabilitation and Health Care Center, Inc.	Cicero
Alden Trails, Inc.	Bloomingdale
Alden - Poplar Creek Rehabilitation and Health Care Center, Inc.	Hoffman Estates
Alden - North Shore Rehabilitation and Health Care Center, Inc.	Skokie
Alden - Des Plaines Rehabilitation and Health Care Center, Inc.	Des Plaines
Alden Estates of Evanston, Inc.	Evanston
Alden - Alma Nelson Manor, Inc.	Rockford
Alden - Park Strathmoor, Inc.	Rockford
Alden - Meadow Park Health Care Center, Inc.	Clinton, WI
Alden Estates of Barrington, Inc.	Barrington
Alden of Waterford, LLC	Aurora
Alden Springs, Inc.	Bloomingdale
Alden Village North, Inc.	Chicago
Alden Estates of Skokie, Inc.	Skokie
Alden Estates of Countryside, Inc.	Jefferson, WI

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Professional Center, LP	Chicago	Home Office rental
Forum Extended Care Services II, Inc.	Chicago	Pharmacy
Alden Management Services, Inc.	Chicago	Management
Alden Gardens of Bloomingdale, Inc.	Bloomingdale	Supportive Living Facility
Alden Garden Courts of DesPlaines, LLC	DesPlaines	Assisted Living/Alzheimers Facility
Alden Courts of Waterford, LLC	Aurora	Alzheimers Facility
Alden Gardens of Waterford, LLC	Aurora	Assisted Living
Prism Health Care Services, Inc.	Schaumburg	Nursing and Durable Equipment
Community Physical Therapy & Associates, Ltd.	Addison	Therapy Provider
Alden Bennett Construction Company, Inc.	Chicago	General Contractor

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	184,214	0.172	0.43	Salary	$ 786	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,348	0.172	0.43	Salary	292	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,352	0.172	0.43	Salary	168	6-7	3
4											4
5											5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10											10
11											11
12											12
13								TOTAL	$ 1,246		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 Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [x] 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	1,283,623	33	$ 71,628	$	5,456	$ 304	1
2	24	Trav & Seminar	Patient Days	1,283,623	33	92,957		5,456	395	2
3	25	Other Admin Travel	Patient Days	1,283,623	33	361,409		5,456	1,536	3
4	26	Insurance	Patient Days	1,283,623	33	3,773		5,456	16	4
5	20	Dues & Subscriptions	Patient Days	1,283,623	33	31,234		5,456	133	5
6	30	Depreciation	No of Providers/usage	33	33	64,513		1	1,549	6
7	33	Real Estate Tax	Patient Days/ysage	1,283,623	33	135,456		5,456	507	7
8	35	Rent-Equip & Vehicle	Patient Days	1,283,623	33	927,091		5,456	3,941	8
9	32	Interest	Patient Days/usage	1,283,623	33	1,179,658		5,456	6,148	9
10	1	Dietary Salary	Patient Days	1,283,623	33	116,597	116,597	5,456	496	10
11	3	Housekeeping Salary	Patient Days	1,283,623	33	157,195	157,195	5,456	668	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,283,623	33	159,672		5,456	679	12
13	10	Nurs & Med Records Salary	Patient Days	1,283,623	33	1,369,902	1,369,902	5,456	5,669	13
14	15	Employee Benefits -Health Care	Patient Days	1,283,623	33	199,071		5,456	846	14
15	17	Administrative Salary	Patient Days/usage	1,283,623	33	2,862,453	2,862,453	5,456	11,158	15
16	27	Employee Benefits - Admin	Patient Days	1,283,623	33	1,372,540		5,456	5,834	16
17	19	Professional fees	Patient Days	1,283,623	33	1,239,391	672,679	5,456	5,288	17
18	21	Gen'I & Admin	Patient Days	1,283,623	33	6,683,349	5,909,984	5,456	28,407	18
19	6	Repair & Maint.	Patient Days	1,283,623	33	1,043,713	824,986	5,456	4,438	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 18,071,602	$ 11,913,796		$ 78,012	25

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Harris (Gl 2512/2021/7044)		x	Mortgage	$10,752.46	12/1/06	$ 1,781,000	$ 1,629,294	11/01/2011	5.2500	$ 87,811	1
2												2
3												3
4												4
5	Insurance Interest		x	Medical Malpractice							200	5
	Working Capital											
6	Related party-AMS		x								6,148	6
7	Related party-FECII		x								9	7
8												8
9	TOTAL Facility Related				$10,752.46		$ 1,781,000	$ 1,629,294			$ 94,168	9
	B. Non-Facility Related*											
10	Interest Inc -Various		x								(46)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (46)	14
15	TOTALS (line 9+line14)						$ 1,781,000	$ 1,629,294			$ 94,122	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.)**

Facility Name & ID Number Alden Springs **#** 0047191 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 2009 report.	$	27,400	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.)	$	27,401	2
3. Under or (over) accrual (line 2 minus line 1).	$	1	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	28,200	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.	$	28,201	7
Plus: Related Party Taxes (2) - See Pg RE_Tax		510	
	$	28,711	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	4,146	8
	2006	3,686	9
	2007	3,525	10
	2008	26,564	11
	2009	27,401	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 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Springs COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0047191

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached supplement	Related Party-Alden Management Ser	$ 287,845.00	$ 507.00
2.	See attached supplement	Related Party-Forum Extended Care	$ 35,344.00	$ 3.00
3.	02-23-300-024	Alden Trails II LLC	$ 27,401.20	$ 27,401.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 350,590.20	$ 27,911.20

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	22,035		$ 398,630	1
2					2
3	TOTALS	22,035		$ 398,630	3

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			2006	$ 1,583,599	$ 39,590	40	$ 39,590	$	$ 168,257	4
5				2006	69,510	1,738	40	1,738		7,386	5
6				2006	20,156	504	40	504		2,352	6
7											7
8							25				8
	Improvement Type**										
9	Wiring			2006	840	42	20	42		179	9
10											10
11	Drywall Carpentry			2007	18,677	1,245	15	1,245		4,565	11
12	Plumb, Floor Prep, Fencing-ABC Renovation			2007	23,127	2,313	10	2,313		9,252	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 1,715,910	$ 45,432		$ 45,432	$	$ 191,991	1
2	Forum Prof Ctr: Remodeling	1979	12,778		20			12,778	2
3	Forum Prof Ctr: Build Improv - multiple	1980	24,885		15			24,885	3
4	Forum Prof Ctr: Tennant Improv	1986	785		13			785	4
5	Forum Prof Ctr: AMS remodel	1990	5,337		10			5,337	5
6	Forum Prof Ctr: Roof	1994	2,815	175	16	175		2,815	6
7	Forum Prof Ctr: Build Improv-multiple	1995	993	62	16	62		927	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,568	112	10	112		1,517	8
9	Forum Prof Ctr: Remodel/electrical	2001	611	33	7	33		544	9
10	Forum Prof Ctr: bathroom remodel	2002	540	50	5	50		452	10
11	Forum Prof Ctr: remodel suites/etc.	2003	694	70	9	70		555	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,138	104	7	104		1,762	12
13	Forum Prof Ctr: Suite renovation	2005	432	62	10	62		485	13
14	Forum Prof Ctr: Superior installations, etc.	2006	85	12	4	12		85	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	415	65	7	65		215	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	346	60	7	60		142	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	715	68	7	68		82	17
18	Forum Prof Ctr: Building Renovations	2010	1,161	330	7	330		330	18
19	Alden Mgt Servs: Remodel suites	1993	7,174	23	7	23		7,163	19
20	Alden Mgt Servs: Remodel suites	2002	299		7			299	20
21	Alden Mgt Servs: Remodel suites	2003	6,486	161	7	161		6,474	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	TOTAL (lines 1 thru 33)		$ 1,786,168	$ 46,819		$ 46,819	$	$ 259,622	34

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 200,105	$ 20,658	$ 20,658	$		$ 84,968	71
72	Current Year Purchases	40,237	1,425	1,425			1,425	72
73	Fully Depreciated Assets	64,257	23	23			64,257	73
74								74
75	TOTALS	$ 304,599	$ 22,106	$ 22,106	$		$ 150,650	75

D. Vehicle Depreciation (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	4,148				3	4,148	79
80	TOTALS			$ 4,148	$	$	$		$ 4,148	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)	$ 2,493,545	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,925	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,925	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)	$ 414,420	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.

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

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

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

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1/1/2007
Ending 11/1/2011

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$ Varies
13.	/2012	$ Varies
14.	/2013	$ Varies

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 5,765 Description: Copy Machine Lease & Various office equipment.
(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	$ 223.58	$ 2,683	17
18					18
19			0.00		19
20					20
21	TOTAL		$ 223.58	$ 2,683	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.

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] 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.

Facility Name & ID Number Alden Springs | STATE OF ILLINOIS # 0047191 | Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				1,732		1,732	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Except Care Prgrm	39-1, 39-3, if any								12
13	Other (specify): See Pg 16A						4,769		4,769	13
14	TOTAL			$		$	$ 6,501		$ 6,501	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.

XIV. Special Services (Direct Cost)

Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.	Page 16 Col 5: PT,OT, & ST Col 6: Supplies
1.	OT	39-3	To Col 5	$1,734.00
2.	ST	39-3	To Col 5	1,028.00
3.				
4.	PT	39-3	To Col 5	3,404.00
5.				
6.				
7.				
8.	Less PT, OT, & ST costs reclassed to Line 10A for "DD type facilities			(6,166.00)
				0.00
	Less: OT, ST, & PT costs - reclassed to 10A for DD facilities			0.00
				0.00
	Phamacy Supplies per GL			1,232.00
	Manual Input from Related Party- Forum Drugs			500.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	1,732.00
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	
	Other			8,563.00
	Manual Input: Related Party - Prism			(3,537.00)
	Manual Input: Related Party FECII - I.V.			(133.00)
	Manual Input: Related Party FECII - Wound Care			(124.00)
	Oxygen, from reclass worksheet (Pg 4A)			
13.	Col 6: Supplies Total		To Col 6	4,769.00
13.	Total Line 13, Column 8			4,769.00
14.	Total			6,501.00

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100))	73,965	73,965	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,925	6
7	Other Prepaid Expenses	1,327	1,327	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties	17,712	17,712	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 93,004	$ 94,929	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,674,106	14
15	Leasehold Improvements, at Historical Cost	18,677	18,677	15
16	Equipment, at Historical Cost	41,891	227,040	16
17	Accumulated Depreciation (book methods)	(11,945)	(269,204)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from Affiliates	207,890	306,205	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 256,513	$ 2,355,455	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 349,517	$ 2,450,384	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,489	$ 235,458	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,180	9,180	28
29	Short-Term Notes Payable		1,629,294	29
30	Accrued Salaries Payable	32,455	32,455	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,190	6,190	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,200	32
33	Accrued Interest Payable		7,366	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp/Insur,DueState,SalesTax,etc.	5,763	5,763	36
37	Due to Affiliates	76,296	76,296	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 281,373	$ 2,030,202	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			43
44	S/holder loans, Others			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 281,373	$ 2,030,202	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 68,144	$ 420,182	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 349,517	$ 2,450,384	48

*(See instructions.)

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (35,191)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2006 cost report	327	3
4	was submitted. These have no effect on prior years report		4
5	Bad debt, Medicare revenues (non allowables)		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (34,864)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,008	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)**	$ 103,008	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)**	$ 68,144	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,202,066	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,202,066	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Page 19A	270,160	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 270,160	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,472,272	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	211,572	31
32	Health Care	387,658	32
33	General Administration	240,930	33
	B. Capital Expense		
34	Ownership	177,542	34
	C. Ancillary Expense		
35	Special Cost Centers	286,110	35
36	Provider Participation Fee	65,452	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,369,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	103,008	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 103,008	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

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

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs # 0047191 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

Details of Page 19, Line 28

Miscellaneous Income-W/C refund	6.91
Miscellaneous Income-Garnishment	2.00
Day Training Income	270,151.32
	270,160.23

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	964	964	27,741	28.78	3
4	Licensed Practical Nurses	2,263	2,516	64,181	25.51	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	115	130	2,672	20.55	13
14	Head Cook	4,167	4,191	50,824	12.13	14
15	Cook Helpers/Assistants	190	190	2,219	11.68	15
16	Dishwashers					16
17	Maintenance Workers	121	130	3,093	23.79	17
18	Housekeepers	1,421	1,522	18,126	11.91	18
19	Laundry					19
20	Administrator	488	510	13,525	26.52	20
21	Assistant Administrator	71	78	2,444	31.33	21
22	Other Administrative	47	52	1,468	28.23	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,642	22,750	249,613	10.97	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Facility Manager	1,944	1,976	35,947	18.19	33
34	TOTAL (lines 1 - 33)	33,433	35,009	$ 471,853 *	$ 13.48	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 1,100	1-3	35
36	Medical Director	250/Monthly	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/Monthly	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,851	22,214	11-3	44
45	Social Service Consultant	69	138		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,920	$ 26,836		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Johnson, Anna	Administrator	0	$ 13,525
Harris, Yvonne	Assistant Admin	0	2,444
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 15,969

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	Consulting Fees	$ 84,145
AMS (Eliminated)	Allocated Legal Fees	2,592
Pathways-reclassed to Nurs.	Clinical Consultants	1,804
Medi.Com	Billing Consultants	43
Linda Robert Ass.	Nutrition service Consl.	330
BDO Seidman/Baker Tilly VK	Accounting Fees	2,372
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 91,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 689
Unemployment Compensation Insurance	4,425
FICA Taxes	33,538
Employee Health Insurance	12,320
Employee Meals	3,019
Illinois Municipal Retirement Fund (IMRF)*	
Dental/Life Insurance	335
Employee Drug Tests/Vaccinations	543
Misc Payroll Costs/401K Match	554
TOTAL (agree to Schedule V, line 22, col.8)	$ 55,422

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	17
Health Care Worker Background Check	
(Indicate # of checks performed 8)	80
Patient Background Checks 30	300
Surety bond fees-Marsh USA Inc.	100
IHCA dues, less pac fees	618
Citi Cards-Annual Report	155
Related party-Trails II,LLC	250
Related party-AMS	133
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,653

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related party-AMS	395
Seminar Expense	
ILL Health care Asso.	461
ILL Council on long Term care	24
Leadership Training	350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,230

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	None for 2010		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Alden Springs **#** 0047191 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 Assn. $ 618**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,916** 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. $ **65,452**
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. $ **3,019** 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 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.