

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

<p>I. IDPH License ID Number: <u>42069</u></p> <p>Facility Name: <u>Alden of Old Town East, Inc.</u></p> <p>Address: <u>108 S. First Street</u> <u>Bloomington</u> <u>60108-2120</u> <small>Number City Zip Code</small></p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630)671-1703</u> Fax # <u>(630)671-1706</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/9/98</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 724-6622</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Alden of Old Town East, Inc.

42069 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	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	5,204	358		5,562	13
14	TOTALS	5,204	358		5,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.24%

D. How many bed-hold days during this year were paid by the Department? 132 (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

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 7/6/98

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

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 N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Alden of Old Town East, Inc. # 42069 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	56,181	5,737	1,200	63,118	96	63,214	50	63,264		1
2	Food Purchase		45,288		45,288	(4,450)	40,838	2,288	43,126		2
3	Housekeeping	10,622	6,423		17,045	1,648	18,693	920	19,613		3
4	Laundry		7,003		7,003		7,003		7,003		4
5	Heat and Other Utilities			18,304	18,304		18,304	285	18,589		5
6	Maintenance	7,655		57,947	65,602		65,602	9,494	75,096		6
7	Other (specify):* Related party							897	897		7
8	TOTAL General Services	74,458	64,451	77,451	216,360	(2,706)	213,654	13,934	227,588		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	452,324	19,364	1,033	472,721	3,549	476,270	4,984	481,254		10
10a	Therapy		150		150	6,466	6,616	(4,673)	1,943		10a
11	Activities		5,942	22,764	28,706		28,706		28,706		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related party							723	723		15
16	TOTAL Health Care and Programs	452,324	25,456	26,797	504,577	10,015	514,592	1,034	515,626		16
	C. General Administration										
17	Administrative	15,605			15,605		15,605	11,149	26,754		17
18	Directors Fees										18
19	Professional Services			107,896	107,896	(2,034)	105,862	(94,809)	11,053		19
20	Dues, Fees, Subscriptions & Promotions			17,629	17,629		17,629	(16,209)	1,420		20
21	Clerical & General Office Expenses	36,280	4,539	10,212	51,031	37	51,068	30,455	81,523		21
22	Employee Benefits & Payroll Taxes			69,260	69,260	1,154	70,414		70,414		22
23	Inservice Training & Education										23
24	Travel and Seminar			15	15		15	379	394		24
25	Other Admin. Staff Transportation			4,105	4,105		4,105	1,931	6,036		25
26	Insurance-Prop.Liab.Malpractice			17,050	17,050		17,050	1,458	18,508		26
27	Other (specify):* Related party			9,848	9,848		9,848	(4,115)	5,733		27
28	TOTAL General Administration	51,885	4,539	236,015	292,439	(843)	291,596	(69,761)	221,835		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	578,667	94,446	340,263	1,013,376	6,466	1,019,842	(54,793)	965,049		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 of Old Town East, Inc.

#42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			3,901	3,901		3,901	40,340	44,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,085	23,085		23,085	50,899	73,984			32
33	Real Estate Taxes			15,432	15,432	(15,432)		11,958	11,958			33
34	Rent-Facility & Grounds			80,601	80,601	15,432	96,033	(96,033)				34
35	Rent-Equipment & Vehicles			4,810	4,810		4,810	4,450	9,260			35
36	Other (specify):* MIP							6,558	6,558			36
37	TOTAL Ownership			127,829	127,829		127,829	18,172	146,001			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,673	6,466	8,139	(6,466)	1,673	(484)	1,189			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,231	67,231		67,231		67,231			42
43	Other (specify):* TranSp,DayTrainl	7,095		267,391	274,486		274,486		274,486			43
44	TOTAL Special Cost Centers	7,095	1,673	341,088	349,856	(6,466)	343,390	(484)	342,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	585,762	96,119	809,180	1,491,061		1,491,061	(37,105)	1,453,956			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		(4,450.00)	Employee Meals
	22	4,450.00	Employee Meals
22		(3,296.00)	Uniforms
	10	1,552.00	Uniforms
	1	96.00	Uniforms
	3	1,648.00	Uniforms
	4	-	Uniforms
	6	-	Uniforms
	11	-	Uniforms
	21	-	Uniforms
10			Oxygen - to appropriate cost center
	39		Oxygen - to appropriate cost center
33		(15,432.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	15,432.00	Rent - Real Estate Tax on associated landowner (Pg 6)
19			Reclass from Professional Fees to Real Estate tax
	33		Reclass from Professional Fees to Real Estate tax
21			Vendor Settlements
			Vendor Settlements (may effect more than one line)
<u>Others, if any:</u>			
19		(1,997.00)	Clinical Coordinators (Pathway Billing)
	10	1,997.00	Clinical Coordinators (Pathway Billing)
19		(37.00)	MediFax/MedCom
	21	37.00	MediFax/MedCom
39		(6,466.00)	PT, OT, ST CPT Therapy Costs
	10A	6,466.00	PT, OT, ST CPT Therapy Costs
Net		<hr/>	-

Alden of Old Town East, Inc.

ID# 42069

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (960)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(2,604)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	4,732	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	9,254	6	4
5				5
6	Elim ABC Deprec Exp from Pg 12 series -	(7)	30	6
7	Reconcile Depreciation expense	(411)	30	7
8	Late Fees on Utilities	(47)	5	8
9	Intercompany Interest	(8,852)	32	9
10	Back out 30% of PAC Fees IHCA	(267)	20	10
11	Prior Year Accrual Adj RE Tax Back out	(2,683)	33	11
12	Back out Group MidCap Legal Fees	(415)	19	12
13	Back out Group MidCap Accounting Fees	(209)	19	13
14	Bloomington Chamber Dues Back out	(125)	20	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,594)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	616	(566)	0	0	0	0	0	0	0	50	1
2	Food Purchase	(170)	0	0	2,458	0	0	0	0	0	0	0	2,288	2
3	Housekeeping	0	0	920	0	0	0	0	0	0	0	0	920	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(47)	0	332	0	0	0	0	0	0	0	0	285	5
6	Maintenance	12,124	0	(2,725)	0	0	0	95	0	0	0	0	9,494	6
7	Other (specify):*	0	0	879	18	0	0	0	0	0	0	0	897	7
8	TOTAL General Services	11,907	0	22	1,910	0	0	95	0	0	0	0	13,934	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,771	2	211	0	0	0	0	0	0	4,984	10
10a	Therapy	0	0	0	0	0	(4,673)	0	0	0	0	0	(4,673)	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	723	0	0	0	0	0	0	0	0	723	15
16	TOTAL Health Care and Programs	0	0	5,494	2	211	(4,673)	0	0	0	0	0	1,034	16
	C. General Administration													
17	Administrative	0	0	11,149	0	0	0	0	0	0	0	0	11,149	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(624)	2,472	(96,657)	0	0	0	0	0	0	0	0	(94,809)	19
20	Fees, Subscriptions & Promotions	(2,847)	135	(13,497)	0	0	0	0	0	0	0	0	(16,209)	20
21	Clerical & General Office Expenses	(83)	0	29,881	422	235	0	0	0	0	0	0	30,455	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	379	0	0	0	0	0	0	0	0	379	24
25	Other Admin. Staff Transportation	0	0	1,931	0	0	0	0	0	0	0	0	1,931	25
26	Insurance-Prop.Liab.Malpractice	0	1,441	17	0	0	0	0	0	0	0	0	1,458	26
27	Other (specify):*	(9,848)	0	5,805	45	(117)	0	0	0	0	0	0	(4,115)	27
28	TOTAL General Administration	(13,402)	4,048	(60,992)	467	118	0	0	0	0	0	0	(69,761)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,495)	4,048	(55,476)	2,379	329	(4,673)	95	0	0	0	0	(54,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011 Ending:

12/31/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(3,982)	36,135	8,187	0	0	0	0	0	0	0	0	40,340	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,852)	52,786	6,957	0	8	0	0	0	0	0	0	50,899	32
33	Real Estate Taxes	(2,683)	14,042	596	0	3	0	0	0	0	0	0	11,958	33
34	Rent-Facility & Grounds	0	(96,033)	0	0	0	0	0	0	0	0	0	(96,033)	34
35	Rent-Equipment & Vehicles	0	0	4,450	0	0	0	0	0	0	0	0	4,450	35
36	Other (specify):*	0	6,558	0	0	0	0	0	0	0	0	0	6,558	36
37	TOTAL Ownership	(15,517)	13,488	20,190	0	11	0	0	0	0	0	0	18,172	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	(498)	14	0	0	0	0	0	0	(484)	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	(498)	14	0	0	0	0	0	0	(484)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(17,012)	17,536	(35,286)	1,881	354	(4,673)	95	0	0	0	0	(37,105)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 96,033	Alden of Bloomingdale Limited Partnership		\$	\$ (96,033)	1
2	V	32 Interest Income - RR	11	Alden of Bloomingdale Limited Partnership			(11)	2
3	V	32 Interest Income	14,011	Alden of Bloomingdale Limited Partnership			(14,011)	3
4	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,472	2,472	4
5	V							5
6	V	20 Dues & Subscriptions/Licenses & Inspections		Alden of Bloomingdale Limited Partnership		135	135	6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		14,042	14,042	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,441	1,441	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,558	6,558	9
10	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership		44,797	44,797	10
11	V	32 Interest - IOD		Alden of Bloomingdale Limited Partnership		21,193	21,193	11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		36,135	36,135	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		818	818	13
14	Total		\$ 110,055			\$ 127,591	\$ * 17,536	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%	\$ 332	\$	332	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		379		379	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,931		1,931	17
18	V	26 Insurance		Alden Management Services, Inc.		17		17	18
19	V	20 Dues & Subscriptions	13,735	Alden Management Services, Inc.		238		(13,497)	19
20	V	30 Depreciation		Alden Management Services, Inc.		8,187		8,187	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		596		596	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		4,450		4,450	22
23	V	32 Interest		Alden Management Services, Inc.		6,957		6,957	23
24	V	1 Dietary		Alden Management Services, Inc.		616		616	24
25	V	3 Houskeeping		Alden Management Services, Inc.		920		920	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		879		879	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		4,771		4,771	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		723		723	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		11,149		11,149	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		5,805		5,805	30
31	V	19 Professional Fees	101,505	Alden Management Services, Inc.		4,848		(96,657)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		29,881		29,881	32
33	V	6 Repairs & Maintenance	8,405	Alden Management Services, Inc.		5,680		(2,725)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 123,645			\$ 88,359	\$ *	(35,286)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary Consultant	\$ 1,200	Prism Health Care Services, Inc.	0.00%	\$ 20	\$ (1,180)	15
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		614	614	16
17	V	2 Tube Feeding		Prism Health Care Services, Inc.		2,458	2,458	17
18	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		362	2	18
19	V	39 Ancillary Supplies	785	Prism Health Care Services, Inc.		287	(498)	19
20	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		270	270	20
21	V	27 Employee Benefits		Prism Health Care Services, Inc.		45	45	21
22	V	7 Employee Benefits		Prism Health Care Services, Inc.		18	18	22
23	V	21 General & Administrative		Prism Health Care Services, Inc.		152	152	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		\$ 2,345			\$ 4,226	\$ * 1,881	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	\$ 335	Forum Extended Care Services II, Inc.	0.00%	\$ 465	\$ 130	15	
16	V	39 Wound Care	553	Forum Extended Care Services II, Inc.		437	(116)	16	
17	V	10 House Stock	1,026	Forum Extended Care Services II, Inc.		949	(77)	17	
18	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		672	288	18	
19	V	27 Employee Vaccination	647	Forum Extended Care Services II, Inc.		512	(135)	19	
20	V	27 Employee Benefits: G & A		Forum Extended Care Services II, Inc.		18	18	20	
21	V	21 Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		148	148	21	
22	V	21 Gen'l & Admin.		Forum Extended Care Services II, Inc.		87	87	22	
23	V	32 Interest		Forum Extended Care Services II, Inc.		8	8	23	
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		3	3	24	
25	V	30 Depreciation		Forum Extended Care Services II, Inc.				25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 2,945			\$ 3,299	\$ *	354	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A Therapy	\$ 6,466	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,793	\$ (4,673)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,466			\$ 1,793	\$ * (4,673)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 12,253	Alden Bennett Construction Company, Inc.	0.00%	\$ 12,348	\$	95	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		\$ 12,253			\$ 12,348	\$ *	95	39

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

Facility Name & ID Number

Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	184,218	0.168	0.00	Salary	\$ 782	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,350	0.168	0.00	Salary	290	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,353	0.168	0.00	Salary	167	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	\$ 1,239		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 of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

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 (773-724-6622
 Fax Number (773-724-6622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	1,315,389	34	\$ 78,619	\$ 5,562	\$ 332	1	
2	24	Trav & Seminar	Patient Days	1,315,389	34	89,570	5,562	379	2	
3	25	Other Admin Travel	Patient Days	1,315,389	34	456,762	5,562	1,931	3	
4	26	Insurance	Patient Days	1,315,389	34	4,082	5,562	17	4	
5	20	Dues & Subscriptions	Patient Days	1,315,389	34	56,361	5,562	238	5	
6	30	Depreciation	No of Providers/usage	34	34	291,758	1	8,187	6	
7	33	Real Estate Tax	Patient Days/ysage	1,315,389	34	156,401	5,562	596	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,315,389	34	1,052,493	5,562	4,450	8	
9	32	Interest	Patient Days/usage	1,315,389	34	1,368,621	5,562	6,957	9	
10	1	Dietary Salary	Patient Days	1,315,389	34	145,718	145,718	5,562	616	10
11	3	Housekeeping Salary	Patient Days	1,315,389	34	217,102	217,102	5,562	920	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,315,389	34	207,899	5,562	879	12	
13	10	Nurs & Med Records Salary	Patient Days/usage	1,315,389	34	1,184,449	1,184,449	5,562	4,771	13
14	15	Employee Benefits -Health Care	Patient Days	1,315,389	34	170,963	5,562	723	14	
15	17	Administrative Salary	Patient Days/usage	1,315,389	34	2,886,253	2,886,253	5,562	11,149	15
16	27	Employee Benefits - Admin	Patient Days	1,315,389	34	1,372,783	5,562	5,805	16	
17	19	Professional fees	Patient Days	1,315,389	34	1,146,467	654,108	5,562	4,848	17
18	21	Gen'I & Admin	Patient Days	1,315,389	34	7,066,809	5,970,419	5,562	29,881	18
19	6	Repair & Maint.	Patient Days	1,315,389	34	1,343,350	1,077,524	5,562	5,680	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 19,296,460	\$ 12,135,573	\$ 88,359	25	

Facility Name & ID Number

Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	Cambridge		x	Operating Loss Loan	\$2,122.29	6/02	\$ 339,267	\$ 308,322	9/37	6.8300	\$ 21,193	1								
2	Cambridge		x	Mortgage	\$4,506.29	9/03	873,700	810,220	8/43	5.5000	44,797	2								
3												3								
4	Amortization-Fin/Refin Fee		x	Financing							818	4								
5	Insurance Interest		x	Medical Malpractice							222	5								
	Working Capital																			
6	Related party-AMS		x	Working Capital							6,957	6								
7	Related party-FECH		x	Working Capital							8	7								
8												8								
9	TOTAL Facility Related				\$6,628.58		\$ 1,212,967	\$ 1,118,542			\$ 73,995	9								
	B. Non-Facility Related*																			
10	Interest Income		x	Replacement Reserve							(11)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (11)	14								
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,118,542			\$ 73,984	15								

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	16,267		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.)		\$	13,616		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,651)		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	14,010		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.		\$	11,359		7
Real Estate Tax History:			Plus: Related Party Taxes (2) - See Pg RE_Tax		599
		\$	11,958		
Real Estate Tax Bill for Calendar Year:	2006	12,976			8
	2007	12,486			9
	2008	13,037			10
	2009	13,168			11
	2010	13,616			12
The current year accrual is based on an estimated 3% increase of the prior year tax.					
				FOR BHF USE ONLY	
				13 FROM R. E. TAX STATEMENT FOR 2010 \$	13
				14 PLUS APPEAL COST FROM LINE 5 \$	14
				15 LESS REFUND FROM LINE 6 \$	15
				16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden of Old Town East, Inc. COUNTY DuPage
 FACILITY IDPH LICENSE NUMBER 42069
 CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll
 TELEPHONE (773) 724-6622 FAX #: (773-283-3997

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> See attached supplement </u>	<u> Related Party-Alden Management Ser </u>	\$ <u> 300,377.00 </u>	\$ <u> 596.00 </u>
2. <u> See attached supplement </u>	<u> Related Party-Forum Extended Care </u>	\$ <u> 42,023.00 </u>	\$ <u> 3.00 </u>
3. <u> 02-15-201-020 </u>	<u> Nursing Home Facility </u>	\$ <u> 13,615.90 </u>	\$ <u> 13,615.90 </u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u> <u> 356,015.90 </u> </u>	\$ <u> <u> 14,214.90 </u> </u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>14,400</u>	<u>1995</u>	<u>\$ 150,686</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	14,400		\$ 150,686	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1997	1997	934,861	23,372	40	23,372		316,138
5									
6									
7									
8									
Improvement Type**									
9	TV Modules		1999	1,775		5			1,775
10	Sprinkler system		2001	2,345	76	10	76		2,345
11									
12	ABC Counter Tops		2003	8,091	809	10	809		7,079
13	ABC roof repair		2003	1,685	168	10	168		1,360
14									
15	Central States Automati(Sprinkler Repair)		2005	1,614	161	10	161		1,101
16	Alden Bennett Const(Door Installation)		2005	1,882	188	10	188		1,238
17									
18	ABC - Replace Resident's Room Ceiling		2009	4,749	475	10	475		1,310
19									
20	Remodel of Kitchen due to extreme wear - ABC		2011	11,117	417	20	417		417
21	Valve Inspections/water gauge on valve replaced - USFIRE		2011	3,703	123	5	123		123
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 971,822	\$ 25,789		\$ 25,789	\$	\$ 332,886	1
2	Forum Prof Ctr: Remodeling	1979	13,418		20			13,418	2
3	Forum Prof Ctr: Build Improv - multiple	1980	26,131		15			26,131	3
4	Forum Prof Ctr: Tennant Improv	1986	824		13			824	4
5	Forum Prof Ctr: AMS remodel	1990	5,604		10			5,604	5
6	Forum Prof Ctr: Roof	1994	2,956		16			2,956	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,042	65	16	65		1,039	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,646	13	10	13		1,605	8
9	Forum Prof Ctr: Remodel/electrical	2001	641	24	7	24		595	9
10	Forum Prof Ctr: bathroom remodel	2002	567	53	5	53		527	10
11	Forum Prof Ctr: remodel suites/etc.	2003	729	74	9	74		657	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,245	104	7	104		1,954	12
13	Forum Prof Ctr: Suite renovation	2005	453	27	10	27		537	13
14	Forum Prof Ctr: Superior installations, etc.	2006	108	3	4	3		108	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	435	68	7	68		294	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	374	54	7	54		208	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	761	73	7	73		162	17
18	Forum Prof Ctr: Building Renovations	2010	1,296	263	7	263		340	18
19	Forum Prof Ctr: Building Renovations	2011	5,684	137	7	137		137	19
20	Alden Mgt Servs: Remodel suites	1993	6,963		7			6,963	20
21	Alden Mgt Servs: Remodel suites	2002	290		7			290	21
22	Alden Mgt Servs: Remodel suites	2003	6,295					6,295	22
23									23
24									24
25									25
26									26
27	Adj for ABC related party profit	2009	(63)	(10)		(10)		(25)	27
28	Adj for ABC related party profit	2011	86	3		3		3	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,050,308	\$ 26,740		\$ 26,740	\$	\$ 403,508	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	\$ 137,505	\$ 14,591	\$ 14,591	\$		\$ 92,181	71
72	Current Year Purchases	26,547	2,910	2,910			2,539	72
73	Fully Depreciated Assets	80,240					80,240	73
74								74
75	TOTALS	\$ 244,292	\$ 17,501	\$ 17,501	\$		\$ 174,960	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	AMS-Bus/Travel Van	Chev/Lumina/00/Various	98-04	\$ 4,634	\$	\$	\$	3	\$ 4,634	76
77	Bills Auto & Truck	Major Capital Repair	2002	817				5	817	77
78	Related Party-AMS	Various	98-'02	4,026				3	4,026	78
79										79
80	TOTALS			\$ 9,477	\$	\$	\$		\$ 9,477	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,454,763	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,241	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,241	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)	\$ 587,945	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 of Old Town East, Inc.

42069

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,810 Description: copy mach gl 6861, postage meter gl 6850, & office equip gl 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party- Pg 6A</u>	<u>various</u>	\$ <u>251.92</u>	\$ <u>3,023</u>	17
18					18
19	<u>Auto lease GL 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>251.92</u>	\$ <u>3,023</u>	21

10. Effective dates of current rental agreement:

Beginning 12/02/1996

Ending 11/30/2036

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

Fiscal Year Ending Annual Rent

12. /2012 \$ varies

13. /2013 \$ varies

14. /2014 \$ varies

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nursing on site</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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 prescripts				464		464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Except Care Prgrm</u>	39-1,39-3, if any								12
13	Other (specify): <u>See Pg 16A</u>						725		725	13
14	TOTAL			\$		\$	1,189		\$ 1,189	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)

Page 16

Col 5: PT,OT, & ST

Col 6: Supplies

Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.	
1.	OT	39-3	To Col 5	\$2,614.05
2.	ST	39-3	To Col 5	1,155.65
3.				
4.	PT	39-3	To Col 5	2,695.94
5.				
6.				
7.				
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facili			(6,466.00)
	Pharmacy Supplies per GL			335.19
	Manual Input from Related Party- Forum Drugs			129.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	464.19
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	0.00
	Other			1,337.65
	Manual Input: Related Party - Prism			(498.00)
	Manual Input: Related Party FECII - I.V.			0.00
	Manual Input: Related Party FECII - Wound Care			(115.00)
	Oxygen, from reclass worksheet (Pg 4A)			
	Rounding			0.36
13.	Col 6: Supplies Total		To Col 6	725.01
13.	Total Line 13, Column 8			725.01
14.	Total			1,188.84

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(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 <u>2,440</u>)	569,163	569,163	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,702	6
7	Other Prepaid Expenses	925	925	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 570,088	\$ 575,790	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	32,619	49,734	15
16	Equipment, at Historical Cost	69,952	209,193	16
17	Accumulated Depreciation (book methods)	(70,995)	(473,026)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		8,782	21
22	Other Long-Term Assets (spe <u>Refinance Fees</u>)		14,658	22
23	Other(specify): <u>Due from affiliates</u>	725,180	941,193	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 756,756	\$ 1,828,884	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,326,844	\$ 2,404,674	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 263,542	\$ 263,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,264	1,264	28
29	Short-Term Notes Payable	3,008	17,315	29
30	Accrued Salaries Payable	43,938	43,938	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,911	6,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		15,400	32
33	Accrued Interest Payable	1,160	5,468	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Exp,Due HFS,SalesTax,Etc.</u>	1,513	1,513	36
37	<u>Due to affiliates</u>	15,493	15,493	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 336,829	\$ 370,855	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		303,772	39
40	Mortgage Payable		800,463	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to affiliates</u>			43
44	<u>S/holder loans, others</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,104,235	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 336,829	\$ 1,475,090	46
47	TOTAL EQUITY(page 18, line 24)	\$ 990,015	\$ 929,584	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,326,844	\$ 2,404,674	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,020,251	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,020,251	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,236)	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)	\$ (30,236)	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)	\$ 990,015	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,192,927	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,192,927	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Income	267,391	28
28a	Gain on Sale of Assets	507	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 267,898	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,460,825	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	216,360	31
32	Health Care	504,577	32
33	General Administration	292,439	33
B. Capital Expense			
34	Ownership	127,829	34
C. Ancillary Expense			
35	Special Cost Centers	282,625	35
36	Provider Participation Fee	67,231	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,491,061	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,236)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,236)	43

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

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

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

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

Facility Name & ID Number Alden of Old Town East, Inc. # 001-7319 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Day Training Income	\$ 267,391
Gain on Sale of Assets	507

Line 28 Total: 267,898

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,506	3,769	124,965	33.16	3
4	Licensed Practical Nurses	1,544	1,684	47,202	28.03	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	73	73	1,532	20.99	13
14	Head Cook	4,408	4,576	54,650	11.94	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	520	520	7,655	14.72	17
18	Housekeepers	1,019	1,080	10,622	9.84	18
19	Laundry					19
20	Administrator	520	520	15,605	30.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	520	520	9,942	19.12	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,238	23,875	270,214	11.32	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Fac Mgr, Tran Sp</u>	2,359	2,396	43,375	18.10	33
34	TOTAL (lines 1 - 33)	36,707	39,013	\$ 585,762 *	\$ 15.01	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	100/month	\$ 1,200	1-3	35
36	Medical Director	250/month	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	32/month	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	414	22,214	11-3	44
45	Social Service Consultant	6	280	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	420	\$ 27,078		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Johnson, Anna	Administrator	0	\$ 15,605	Workers' Compensation Insurance	\$ 11,845	IDPH License Fee	\$	
		0		Unemployment Compensation Insurance	3,942	Advertising: Employee Recruitment		
		0		FICA Taxes	39,016	Health Care Worker Background Check		
		0		Employee Health Insurance	9,043	(Indicate # of checks performed <u>7</u>)	70	
		0		Employee Meals	4,450	Patient Background Checks	0	
		0		Illinois Municipal Retirement Fund (IMRF)*		IHCA dues less PAC fees	623	
		0		Dental Insurance	52	Surety Bond Fees	150	
				Life Insurance	404	Allscripts	205	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 15,605	Employee Relations	392	Related party - Bloomingdale	135	
(List each licensed administrator separately.)				Miscellaneous Payroll Costs	259	Related Party - AMS	238	
B. Administrative - Other								
Description			Amount	Employee Drug Test	96	Less: Public Relations Expense	()	
			\$	401K Match	268	Non-allowable advertising	()	
				Employee Vaccinations	647	Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 70,414	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,420	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
Alden Management Services, Inc.	Consulting		\$ 83,505				Out-of-State Travel	\$
AMS (Eliminated)	Allocated Legal Fees		18,000					
MidCap (Eliminated)	Allocated Legal Fees		415					
Pathway	Clinical Coordinator		1,997				In-State Travel	
Medifax/EDI	Billing Service		37					
MidCap (Eliminated)	Allocated Accounting Fees		208					
BDO Seidman	Accounting Fees		1,955				Related Party - AMS	379
Baker Tilly/Virchow Krause	Audit Fees		1,779				Seminar Expense	
							IHCA	15
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 107,896	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 394
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting	02/06	\$ 2,675	3	\$ 892	\$ 892	\$ 149	\$	\$	\$	\$	\$													
2	Painting	05/09	3,300	3			733	1,100	1,100	367															
3																									
4																									
5																									
6																									
7																									
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17																									
18																									
19																									
20	TOTALS		\$ 5,975		\$ 892	\$ 892	\$ 882	\$ 1,100	\$ 1,100	\$ 367	\$	\$													

Facility Name & ID Number Alden of Old Town East, Inc.

42069

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA=\$623
- (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. \$ 6,930 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,231
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. \$ 4,450 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.