FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 004-7191

Facility Name: Alden Springs, Inc.

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) 724-6622
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Joan Carl
(Title) Vice-President

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

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 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 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	5,371			5,371	13
14	TOTALS	5,371			5,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.97%

D. How many bed-hold days during this year were paid by the Department?
346 (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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 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	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	52,196	4,152	1,200	57,548	1,881	59,429	29	59,458			1
2	Food Purchase		53,583		53,583	(3,232)	50,351	(13,461)	36,890			2
3	Housekeeping	12,466	6,007		18,473		18,473	886	19,359			3
4	Laundry		4,123		4,123		4,123		4,123			4
5	Heat and Other Utilities			22,646	22,646		22,646	260	22,906			5
6	Maintenance	7,655		42,510	50,165		50,165	2,657	52,822			6
7	Other (specify):* Related party							1,102	1,102			7
8	TOTAL General Services	72,317	67,865	66,356	206,538	(1,351)	205,187	(8,527)	196,660			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	384,476	19,835	910	405,221	3,768	408,989	4,818	413,807			10
10a	Therapy		405		405	6,550	6,955	(5,057)	1,898			10a
11	Activities			22,764	22,764		22,764		22,764			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							698	698			15
16	TOTAL Health Care and Programs	384,476	20,240	26,674	431,390	10,318	441,708	459	442,167			16
	C. General Administration											
17	Administrative	15,605			15,605		15,605	10,766	26,371			17
18	Directors Fees											18
19	Professional Services			107,447	107,447	(2,275)	105,172	(96,428)	8,744			19
20	Dues, Fees, Subscriptions & Promotions			16,806	16,806		16,806	(15,128)	1,678			20
21	Clerical & General Office Expenses	43,402	2,184	7,157	52,743	37	52,780	33,932	86,712			21
22	Employee Benefits & Payroll Taxes			77,315	77,315	(179)	77,136		77,136			22
23	Inservice Training & Education											23
24	Travel and Seminar			15	15		15	366	381			24
25	Other Admin. Staff Transportation			2,938	2,938		2,938	1,865	4,803			25
26	Insurance-Prop.Liab.Malpractice			17,050	17,050		17,050	2,182	19,232			26
27	Other (specify):* Related party			8,216	8,216		8,216	(2,010)	6,206			27
28	TOTAL General Administration	59,007	2,184	236,944	298,135	(2,417)	295,718	(64,455)	231,263			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	515,800	90,289	329,974	936,063	6,550	942,613	(72,523)	870,090			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, Inc. #004-7191 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			5,224	5,224		5,224	59,667	64,891			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,074	9,074		9,074	87,231	96,305			32
33	Real Estate Taxes			28,981	28,981	(28,981)		29,562	29,562			33
34	Rent-Facility & Grounds			121,942	121,942	28,981	150,923	(150,923)				34
35	Rent-Equipment & Vehicles			5,132	5,132		5,132	4,298	9,430			35
36	Other (specify):*											36
37	TOTAL Ownership			170,353	170,353		170,353	29,835	200,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,581	6,550	21,131	(6,550)	14,581	(7,554)	7,027			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,686	67,686		67,686		67,686			42
43	Other (specify):* Day Training/Tran	7,095		272,602	279,697		279,697		279,697			43
44	TOTAL Special Cost Centers	7,095	14,581	346,838	368,514	(6,550)	361,964	(7,554)	354,410			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	522,895	104,870	847,165	1,474,930		1,474,930	(50,242)	1,424,688			45

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

Alden Springs, Inc. IDPH Facility No. 004-7191
Report Period Beginning: 1/1/2011
Ending: 12/31/2011

Reclassifications - Pages 3 & 4, Column 5

From Line	To Line	Amount	Description
2		(3,232.00)	Employee Meals
	22	3,232.00	Employee Meals
22		(3,411.00)	Uniforms
	10	1,530.00	Uniforms
	1	1,881.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
33		(28,981.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	28,981.00	Rent - Real Estate Tax on associated landowner (Pg 6)
Others, if any:			
19		(2,237.90)	Clinical Coordinators (Pathway Billing)
	10	2,237.90	Clinical Coordinators (Pathway Billing)
19		(36.55)	MediFax/MedCom
	21	36.55	MediFax/MedCom
DD Providers Only:			
39		(6,550.00)	PT, OT, & ST CPT Therapy Costs
	10A	6,550.00	PT, OT, & ST CPT Therapy Costs
Net		-	

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	(1,902)	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				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	(1,183)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(420)	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	(8,215)	27		24
25	Fund Raising, Advertising and Promotional	(1,063)	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)**	$ (12,783)		$	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)	(21,224)	Various	34
35	Other- Attach Schedule	(16,235)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (37,459)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (50,242)		37

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

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

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

STATE OF ILLINOIS

Alden Springs, Inc.

ID# 004-7191

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 -	$ (42)	30	1
2	Elim Deprec Exp on Pg 13 items under $2500 -	(7,724)	30	2
3	Expense Pg 12 items under $2,500 - curr yr purchs +	0	6	3
4	Expense Pg 13 items under $2,500 - curr yr purchs +	2,481	6	4
5	Elim. MidCap Legal/Acctg fees	(624)	19	5
6	Misc.Depreciation adjustment	43	30	6
7	Late Fees on Utilities	(61)	5	7
8	Intercompany Interest Not allowed (GL#7031)	(8,852)	32	8
9	Back out 30% (for 2011) of PAC fees	(265)	20	9
10	Elim. Landowner Re. Tax Penalty	(1,057)	32	10
11	Elim. Landowner-Porp. Insurance Interest	(9)	32	11
12	Elim. Bloomingdale Chambers-Membership Fees	(125)	20	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
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**	(16,235)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs, Inc. # 004-7191 **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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	595	(566)	0	0	0	0	0	0	0	29	1
2	Food Purchase	0	0	0	(13,461)	0	0	0	0	0	0	0	(13,461)	2
3	Housekeeping	0	0	886	0	0	0	0	0	0	0	0	886	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(61)	0	321	0	0	0	0	0	0	0	0	260	5
6	Maintenance	579	0	2,020	0	0	0	58	0	0	0	0	2,657	6
7	Other (specify):*	0	0	849	253	0	0	0	0	0	0	0	1,102	7
8	**TOTAL General Services**	518	0	4,671	(13,774)	0	0	58	0	0	0	0	(8,527)	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	4,607	2	209	0	0	0	0	0	0	4,818	10
10a	Therapy	0	0	0	0	0	(5,057)	0	0	0	0	0	(5,057)	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	698	0	0	0	0	0	0	0	0	698	15
16	**TOTAL Health Care and Programs**	0	0	5,305	2	209	(5,057)	0	0	0	0	0	459	16
	C. General Administration													
17	Administrative	0	0	10,766	0	0	0	0	0	0	0	0	10,766	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(624)	42	(95,846)	0	0	0	0	0	0	0	0	(96,428)	19
20	Fees, Subscriptions & Promotions	(1,873)	250	(13,505)	0	0	0	0	0	0	0	0	(15,128)	20
21	Clerical & General Office Expenses	(1,183)	0	28,855	5,935	325	0	0	0	0	0	0	33,932	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	366	0	0	0	0	0	0	0	0	366	24
25	Other Admin. Staff Transportation	0	0	1,865	0	0	0	0	0	0	0	0	1,865	25
26	Insurance-Prop.Liab.Malpractice	0	2,165	17	0	0	0	0	0	0	0	0	2,182	26
27	Other (specify):*	(8,215)	0	5,605	633	(33)	0	0	0	0	0	0	(2,010)	27
28	**TOTAL General Administration**	(11,895)	2,457	(61,877)	6,568	292	0	0	0	0	0	0	(64,455)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,377)	2,457	(51,901)	(7,204)	501	(5,057)	58	0	0	0	0	(72,523)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Springs, Inc. # 004-7191 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,723)	59,203	8,187	0	0	0	0	0	0	0	0	59,667	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,918)	90,209	6,929	0	11	0	0	0	0	0	0	87,231	32
33	Real Estate Taxes	0	28,981	576	0	5	0	0	0	0	0	0	29,562	33
34	Rent-Facility & Grounds	0	(150,923)	0	0	0	0	0	0	0	0	0	(150,923)	34
35	Rent-Equipment & Vehicles	0	0	4,298	0	0	0	0	0	0	0	0	4,298	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,641)	27,470	19,990	0	16	0	0	0	0	0	0	29,835	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	(8,000)	446	0	0	0	0	0	0	(7,554)	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	(8,000)	446	0	0	0	0	0	0	(7,554)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(29,018)	29,927	(31,911)	(15,204)	963	(5,057)	58	0	0	0	0	(50,242)	45

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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. [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	$ 150,923	Alden Trails II, LLC	0.00%	$	$ (150,923)	1
2	V	19	Bank Charges		Alden Trails II, LLC		42	42	2
3	V	20	Dues & Subscriptions		Alden Trails II, LLC				3
4	V	33	Real Estate Tax Expense		Alden Trails II, LLC		28,981	28,981	4
5	V	26	General Insurance Expense		Alden Trails II, LLC		2,165	2,165	5
6	V	32	Interest - Harris/Other		Alden Trails II, LLC		89,153	89,153	6
7	V	30	Depreciation		Alden Trails II, LLC		59,203	59,203	7
8	V	32	Tax Penalty		Alden Trails II, LLC		1,056	1,056	8
9	V	20	Corporate Annual Report Fee		Alden Trails II, LLC		250	250	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 150,923			$ 180,850	$ * 29,927	14

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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%	$ 321	$ 321	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		366	366	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,865	1,865	17
18	V	26	Insurance		Alden Management Services, Inc.		17	17	18
19	V	20	Dues/Subscriptions	13,735	Alden Management Services, Inc.		230	(13,505)	19
20	V	30	Depreciation		Alden Management Services, Inc.		8,187	8,187	20
21	V	33	Real Estate Tax		Alden Management Services, Inc.		576	576	21
22	V	35	Rent-Equip/Vehic		Alden Management Services, Inc.		4,298	4,298	22
23	V	32	Interest		Alden Management Services, Inc.		6,929	6,929	23
24	V	1	Dietary Salary		Alden Management Services, Inc.		595	595	24
25	V	3	Housekeeping Salary		Alden Management Services, Inc.		886	886	25
26	V	7	Employee Benef-Gen'l Servs		Alden Management Services, Inc.		849	849	26
27	V	10	Nurs/Med Rec Salary		Alden Management Services, Inc.		4,607	4,607	27
28	V	15	Employee Benef-Health Care		Alden Management Services, Inc.		698	698	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		10,766	10,766	29
30	V	27	Employee Benef-Administrative		Alden Management Services, Inc.		5,605	5,605	30
31	V	19	Professional Fees	100,527	Alden Management Services, Inc.		4,681	(95,846)	31
32	V	21	Gen'l & Admin		Alden Management Services, Inc.		28,855	28,855	32
33	V	6	Repair & Mainten.	3,465	Alden Management Services, Inc.		5,485	2,020	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 117,727			$ 85,816	$ * (31,911)	39

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 1,200	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	19,169	Prism Health Care Services, Inc.		5,708	(13,461)	17
18	V	10	Equipment Rental	360	Prism Health Care Services, Inc.		362	2	18
19	V	39	Supplies	12,230	Prism Health Care Services, Inc.		4,230	(8,000)	19
20	V	21	Salary G & A		Prism Health Care Services, Inc.		3,796	3,796	20
21	V	27	Employee Benefits		Prism Health Care Services, Inc.		633	633	21
22	V	7	Employee Benefits		Prism Health Care Services, Inc.		253	253	22
23	V	21	G & A		Prism Health Care Services, Inc.		2,139	2,139	23
24	V				Prism Health Care Services, Inc.				24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,959			$ 17,755	$ * (15,204)	39

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 1,576	Forum Extended Care Services II, Inc.	0.00%	$ 2,184	$ 608	15
16	V	39	IV		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care	775	Forum Extended Care Services II, Inc.		613	(162)	17
18	V	10	House Stock	1,053	Forum Extended Care Services II, Inc.		974	(79)	18
19	V	10	Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		672	288	19
20	V	27	Employee Vaccinations	284	Forum Extended Care Services II, Inc.		225	(59)	20
21	V	27	Employee Benefit: G & A		Forum Extended Care Services II, Inc.		26	26	21
22	V	21	Salary: G & A		Forum Extended Care Services II, Inc.		205	205	22
23	V	21	General & Administrative		Forum Extended Care Services II, Inc.		120	120	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		11	11	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		5	5	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			$ 4,072			$ 5,035	$ * 963	39

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 6,550	Community Physical Therapy & Associates, Ltd.	0.00%	$ 1,493	$ (5,057)	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			$ 6,550			$ 1,493	$ * (5,057)	39

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 7,483	Alden Bennett Construction Company, Inc.	0.00%	$ 7,541	$ 58	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			$ 7,483			$ 7,541	$ * 58	39

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 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 Ca	Long Grove				3
4			Alden-Lincoln Park Rehabilitation and Health Ca	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 of Old Town East, Inc.	Bloomingdale	Alden Gardens of Bloom	Bloomingdale	Supportive Living Fac	7
8			Alden Terrace of McHenry Rehabilitation and He	McHenry	Alden Garden Courts of	DesPlaines	Assisted Living/Alzhei	8
9			Alden - Wentworth Rehabilitation and Health Ca	Chicago	Alden Courts of Waterfo	Aurora	Alzheimers Facility	9
10			Alden Estates of Naperville, Inc.	Naperville	Alden Gardens of Water	Aurora	Assisted Living	10
11			Alden - Valley Ridge Rehabilitation and Health C	Bloomingdale	Prism Health Care Servi	Schaumburg	Nursing and Durable I	11
12			Alden Village Health Facility for Children and Yo	Bloomingdale	Community Physical The	Addison	Therapy Provider	12
13			Alden - Orland Park Rehabilitation and Health Ca	Orland Park	Alden Bennett Construct	Chicago	General Contractor	13
14			Alden - Princeton Rehabilitation and Health Car	Chicago	Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable I	14
15			Alden of Old Town West, Inc.	Bloomingdale	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	15
16			Alden - Town Manor Rehabilitation and Health C	Cicero				16
17			Alden Trails, Inc.	Bloomingdale				17
18			Alden - Poplar Creek Rehabilitation and Health (	Hoffman Estates				18
19			Alden - North Shore Rehabilitation and Health C	Skokie				19
20			Alden - Des Plaines Rehabilitation and Health Ca	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 Village North, Inc.	Chicago				27
28			Alden Estates of Skokie, Inc.	Skokie				28
29			Alden Estates of Countryside, Inc.	Jefferson, WI				29
30								30

Facility Name & ID Number Alden Springs, Inc. # 004-7191 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	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	185,000	0.164	0.41	Salary	$ 755	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,640	0.164	0.41	Salary	280	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,520	0.164	0.41	Salary	161	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	$ 1,196		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, Inc. # 004-7191 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 [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: (773-724-6622
Fax Number: (773-724-6622

	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	1,315,389	34	$ 78,619	$	5,371	$ 321	1
2	24	Trav & Seminar	Patient Days	1,315,389	34	89,570		5,371	366	2
3	25	Other Admin Travel	Patient Days	1,315,389	34	456,762		5,371	1,865	3
4	26	Insurance	Patient Days	1,315,389	34	4,082		5,371	17	4
5	20	Dues & Subscriptions	Patient Days	1,315,389	34	56,361		5,371	230	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		5,371	576	7
8	35	Rent-Equip & Vehicle	Patient Days	1,315,389	34	1,052,493		5,371	4,298	8
9	32	Interest	Patient Days/usage	1,315,389	34	1,368,621		5,371	6,929	9
10	1	Dietary Salary	Patient Days	1,315,389	34	145,718	145,718	5,371	595	10
11	3	Housekeeping Salary	Patient Days	1,315,389	34	217,102	217,102	5,371	886	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,315,389	34	207,899		5,371	849	12
13	10	Nurs & Med Records Salary	Patient Days/usage	1,315,389	34	1,184,449	1,184,449	5,371	4,607	13
14	15	Employee Benefits -Health Care	Patient Days	1,315,389	34	170,963		5,371	698	14
15	17	Administrative Salary	Patient Days/usage	1,315,389	34	2,886,253	2,886,253	5,371	10,766	15
16	27	Employee Benefits - Admin	Patient Days	1,315,389	34	1,372,783		5,371	5,605	16
17	19	Professional fees	Patient Days	1,315,389	34	1,146,467	654,108	5,371	4,681	17
18	21	Gen'I & Admin	Patient Days	1,315,389	34	7,066,809	5,970,419	5,371	28,855	18
19	6	Repair & Maint.	Patient Days	1,315,389	34	1,343,350	1,077,524	5,371	5,485	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 19,296,460	$ 12,135,573		$ 85,816	25

Facility Name & ID Number Alden Springs, Inc. # 004-7191 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	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	$	11/01/2011	5.2500	$ 78,793	1
2	Harris (Gl 2512/2021/7044)		x	Mortgage	$10,752.46	1/13/12	1,589,811	1,589,811	06/01/2012	6.0000	10,349	2
3												3
4												4
5	Insurance Interest		x	Medical Malpractice							222	5
	Working Capital											
6	Related party-AMS		x	Working Capital							6,929	6
7	Related party-FECII		x	Working Capital							11	7
8												8
9	TOTAL Facility Related				$21,504.92		$ 3,370,811	$ 1,589,811			$ 96,305	9
	B. Non-Facility Related*											
10	Interest (Inc) -Various		x									10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,370,811	$ 1,589,811			$ 96,305	15

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,200	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.)		$ 28,181	2
3. Under or (over) accrual (line 2 minus line 1).		$ (19)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,000	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.		$ 28,981	7
	Plus: Related Party Taxes (2) - See Pg RE_Tax	581	
		$ 29,562	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	3,686	8
	2007	3,525	9
	2008	26,564	10
	2009	27,401	11
	2010	28,181	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 Springs, Inc. COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 004-7191

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached supplement	Related Party-Alden Management Ser	$ 300,377.00	$ 576.00
2.	See attached supplement	Related Party-Forum Extended Care	$ 42,023.00	$ 5.00
3.	02-23-300-024	Alden Trails II LLC	$ 28,181.20	$ 28,181.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 370,581.20	$ 28,762.20

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 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 Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	Nursing facility	22,035		$ 398,630	1
2					2
3	TOTALS	22,035		$ 398,630	3

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			2006	$ 1,583,599	$ 39,590	40	$ 39,590	$	$ 207,847	4
5				2006	69,510	1,738	40	1,738		9,124	5
6				2006	20,156	504	40	504		2,856	6
7											7
8							25				8
	Improvement Type**										
9	Wiring			2006	840	42	20	42		221	9
10											10
11	Drywall Carpentry			2007	18,677	1,245	15	1,245		5,810	11
12	Plumb, Floor Prep, Fencing-ABC Renovation			2007	23,127	2,313	10	2,313		11,565	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, Inc. # 004-7191 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 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	$	$ 237,423	1
2	Forum Prof Ctr: Remodeling	1979	13,418		20			13,418	2
3	Forum Prof Ctr: Build Improv - multiple	1980	26,131		15			26,131	3
4	Forum Prof Ctr: Tennant Improv	1986	824		13			824	4
5	Forum Prof Ctr: AMS remodel	1990	5,604		10			5,604	5
6	Forum Prof Ctr: Roof	1994	2,956		16			2,956	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,042	65	16	65		1,039	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,646	13	10	13		1,605	8
9	Forum Prof Ctr: Remodel/electrical	2001	641	24	7	24		595	9
10	Forum Prof Ctr: bathroom remodel	2002	567	53	5	53		527	10
11	Forum Prof Ctr: remodel suites/etc.	2003	729	74	9	74		657	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,245	104	7	104		1,954	12
13	Forum Prof Ctr: Suite renovation	2005	453	27	10	27		537	13
14	Forum Prof Ctr: Superior installations, etc.	2006	108	3	4	3		108	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	435	68	7	68		294	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	374	54	7	54		208	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	761	73	7	73		162	17
18	Forum Prof Ctr: Building Renovations	2010	1,296	263	7	263		340	18
19	Forum Prof Ctr: Building Renovations	2011	5,684	137	7	137		137	19
20	Alden Mgt Servs: Remodel suites	1993	6,963		7			6,963	20
21	Alden Mgt Servs: Remodel suites	2002	290		7			290	21
22	Alden Mgt Servs: Remodel suites	2003	6,295		7			6,295	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,794,373	$ 46,390		$ 46,390	$	$ 308,067	34

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 174,187	$ 12,956	$ 12,956	$		$ 46,822	71
72	Current Year Purchases	21,031	2,169	2,169			2,169	72
73	Fully Depreciated Assets	80,574	3,376	3,376			80,574	73
74								74
75	TOTALS	$ 275,792	$ 18,501	$ 18,501	$		$ 129,565	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Related Party - AMS	Various	98-'02	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)	$ 2,472,943	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 64,891	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,891	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)	$ 441,780	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, Inc. # 004-7191 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 [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 11/1/2016

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

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: $ 5,362 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	$ 243.25	$ 2,919	17
18					18
19			0.00		19
20					20
21	TOTAL		$ 243.25	$ 2,919	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, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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, Inc. STATE OF ILLINOIS # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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				2,184		2,184	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						4,844		4,844	13
14	TOTAL			$		$	$ 7,027		$ 7,027	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	$2,731.54
2.	ST	39-3	To Col 5	855.91
3.				
4.	PT	39-3	To Col 5	2,962.31
5.				
6.				
7.				
8.	Less PT, OT, & ST costs reclassed to Line 10A for "DD type facilities			(6,549.76)
				0.00
	Less: OT, ST, & PT costs - reclassed to 10A for DD facilities			0.00
				0.00
	Phamacy Supplies per GL			1,575.65
	Manual Input from Related Party- Forum Drugs			608.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	2,183.65
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			13,005.71
	Manual Input: Related Party - Prism			(8,000.00)
	Manual Input: Related Party FECII - I.V.			0.00
	Manual Input: Related Party FECII - Wound Care			(162.00)
	Oxygen, from reclass worksheet (Pg 4A)			
13.	Col 6: Supplies Total		To Col 6	4,843.71
13.	Total Line 13, Column 8			4,843.71
14.	Total			7,027.36

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs, Inc. # 004-7191 **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	$	$ 5,142	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100))	692,332	692,332	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,969	6
7	Other Prepaid Expenses	1,641	1,641	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 693,973	$ 701,084	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	53,033	238,182	16
17	Accumulated Depreciation (book methods)	(17,169)	(333,631)	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 (spe **Repl resrv, CIP, S/holders**			22
23	Other(specify): Due from affiliates			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 54,541	$ 1,995,964	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 748,514	$ 2,697,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,525	$ 334,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10	10	28
29	Short-Term Notes Payable		1,589,811	29
30	Accrued Salaries Payable	41,943	41,943	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,734	6,734	31
32	Accrued Real Estate Taxes(Sch.IX-B)		29,000	32
33	Accrued Interest Payable		17,715	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp/Insurance	5,987	5,987	36
37	Due to affiliates	97,069	97,069	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 396,268	$ 2,122,685	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	202,325	102,333	43
44	S/holder loans, others			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 202,325	$ 102,333	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 598,593	$ 2,225,018	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 149,921	$ 472,031	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 748,514	$ 2,697,049	48

***(See instructions.)**

Facility Name & ID Number Alden Springs, Inc. # 004-7191 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 68,144	1
2	Restatements (describe):		2
3	external audit adjustments made after 2006 cost report		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)**	$ 68,144	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(23,374)	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) Cumulative affect: cost allocations	105,150	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 81,776	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)**	$ 149,921	24 *

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

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,178,955	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,178,955	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	272,602	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 272,602	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,451,556	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	206,538	31
32	Health Care	431,390	32
33	General Administration	298,135	33
	B. Capital Expense		
34	Ownership	170,353	34
	C. Ancillary Expense		
35	Special Cost Centers	300,828	35
36	Provider Participation Fee	67,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,474,930	40
41	**Income before Income Taxes (line 30 minus line 40)****	(23,374)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (23,374)	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 Springs, Inc. # 004-7191 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 # 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	1,213	1,247	35,582	28.53	3
4	Licensed Practical Nurses	2,398	2,506	61,108	24.38	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	3,762	3,922	50,450	12.86	14
15	Cook Helpers/Assistants	24	24	214	8.92	15
16	Dishwashers					16
17	Maintenance Workers	520	520	7,655	14.72	17
18	Housekeepers	914	1,054	12,466	11.83	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)	22,739	24,216	277,844	11.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Facility/Transport	2,559	2,596	50,497	19.45	33
34	TOTAL (lines 1 - 33)	35,242	37,198	$ 522,895 *	$ 14.06	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	100/Monthly	$ 1,200	1-3	35
36	Medical Director	250/Monthly	3,000	9-3	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	1852/Monthly	22,214	11-3	44
45	Social Service Consultant		280	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,078		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, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Johnson, Anna	Administrator	0	$ 15,605
		0	
		0	
		0	
		0	
		0	
		0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 15,605

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	$ 82,527
AMS (Eliminated)	Allocated Legal Fees	18,000
Pathways-reclassed to Nurs.	Clinical Consultants	2,238
Medi.Com	Billing Consultants	37
Alden Group-MidCap (Eliminated)	Legal Fees/Acctg fee	624
BDO Seidman/Baker Tilly VK	Accounting Fees	3,734
First Advantage Corporation	Tax Credit Services	288
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 107,447

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,661
Unemployment Compensation Insurance	5,136
FICA Taxes	36,370
Employee Health Insurance	18,040
Employee Meals	3,232
Illinois Municipal Retirement Fund (IMRF)*	
Dental/Life Insurance	280
Employee Drug Tests/Vaccinations	764
Misc Payroll Costs/401K Match	469
Employee Relations	184
TOTAL (agree to Schedule V, line 22, col.8)	$ 77,136

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	0
Health Care Worker Background Check	
(Indicate # of checks performed 11)	250
Patient Background Checks 0	0
Surety bond fees-Marsh USA Inc.	175
IHCA dues, less pac fees	618
Citi Cards-Annual Report	405
Related parties	230
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related parties	366
Seminar Expense	
ILL Council on long Term care	15
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 381

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Springs, Inc. # 004-7191 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 2011		$		$	$	$	$	$	$	$	$	$
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, Inc. # 004-7191 **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. 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. $ 6,464 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. $ 67,686
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. $ 3,232 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? 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.