

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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><b>I. IDPH License ID Number:</b> <u>0042051</u></p> <p><b>Facility Name:</b> <u>Alden Trails</u></p> <p><b>Address:</b> <u>273 Army Trails Road</u> <u>Bloomington</u> <u>60108</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630) 671-1990</u> <b>Fax #</b> <u>(630) 671-0540</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>05/19/98</u></p> <p><b>Type of Ownership:</b></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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773)286-3883</u>  <b>Email Address:</b> _____</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/2014</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:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Steve Kroll</u>            (Title) <u>Chief Financial Officer, Alden Management Services as agent</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Steve Kroll</u> (Title) <u>Chief Financial Officer, Alden Management Services as agent</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>Steve Kroll</u> (Title) <u>Chief Financial Officer, Alden Management Services as agent</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Alden Trails

# 0042051 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,586			5,586	13
14	TOTALS	5,586			5,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.65%

D. How many bed-hold days during this year were paid by the Department? 88 (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 08/15/98

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: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	<b>A. General Services</b>										
1	Dietary	62,229	3,186	3,000	68,415	572	68,987	(1,244)	67,743		1
2	Food Purchase		49,843		49,843	(8,910)	40,933	(3,860)	37,073		2
3	Housekeeping	21,217	6,331		27,548		27,548	1,042	28,590		3
4	Laundry		3,689		3,689		3,689		3,689		4
5	Heat and Other Utilities			19,784	19,784		19,784	(72)	19,712		5
6	Maintenance			60,627	60,627	483	61,110	7,114	68,224		6
7	Other (specify):* related party							1,283	1,283		7
8	<b>TOTAL General Services</b>	83,446	63,049	83,411	229,906	(7,855)	222,051	4,263	226,314		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,100	5,100		5,100		5,100		9
10	Nursing and Medical Records	481,690	26,013	1,725	509,428	465	509,893	5,579	515,472		10
10a	Therapy		72		72	6,557	6,629	832	7,461		10a
11	Activities	10,609	56	640	11,305		11,305		11,305		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							912	912		15
16	<b>TOTAL Health Care and Programs</b>	492,299	26,141	7,465	525,905	7,022	532,927	7,323	540,250		16
	<b>C. General Administration</b>										
17	Administrative	14,650			14,650		14,650	22,118	36,768		17
18	Directors Fees										18
19	Professional Services			89,993	89,993		89,993	(64,801)	25,192		19
20	Dues, Fees, Subscriptions & Promotions			6,364	6,364		6,364	(4,274)	2,090		20
21	Clerical & General Office Expenses		1,412	18,442	19,854		19,854	41,101	60,955		21
22	Employee Benefits & Payroll Taxes			111,988	111,988	7,873	119,861		119,861		22
23	Inservice Training & Education										23
24	Travel and Seminar							193	193		24
25	Other Admin. Staff Transportation			3,006	3,006		3,006	1,856	4,862		25
26	Insurance-Prop.Liab.Malpractice			20,047	20,047		20,047	1,784	21,831		26
27	Other (specify):* related party			705	705		705	7,401	8,106		27
28	<b>TOTAL General Administration</b>	14,650	1,412	250,545	266,607	7,873	274,480	5,378	279,858		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	590,395	90,602	341,421	1,022,418	7,040	1,029,458	16,964	1,046,422		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	<b>D. Ownership</b>											
30	Depreciation			8,034	8,034	(483)	7,551	37,681	45,232			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,077	24,077		24,077	18,440	42,517			32
33	Real Estate Taxes			17,856	17,856	(17,856)		22,059	22,059			33
34	Rent-Facility & Grounds			59,754	59,754	17,856	77,610	(77,610)				34
35	Rent-Equipment & Vehicles			6,364	6,364		6,364	6,123	12,487			35
36	Other (specify):* MIP							5,868	5,868			36
37	<b>TOTAL Ownership</b>			116,085	116,085	(483)	115,602	12,561	128,163			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,355	6,557	46,912	(6,557)	40,355	(24,782)	15,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,562	69,562		69,562		69,562			42
43	Other (specify):* DT-Transport. Spe	6,396		258,453	264,849		264,849		264,849			43
44	<b>TOTAL Special Cost Centers</b>	6,396	40,355	334,572	381,323	(6,557)	374,766	(24,782)	349,984			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	596,791	130,957	792,078	1,519,826		1,519,826	4,743	1,524,569			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		\$ (8,910.00)	Employee Meals
	22	\$ 8,910.00	Employee Meals
22		\$ (1,037.00)	Uniforms
	1	\$ 572.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	10	\$ 465.00	Uniforms
	11		Uniforms
	21		Uniforms
10		\$ -	Oxygen - to appropriate cost center
	39	\$ -	Oxygen - to appropriate cost center
33		\$ (17,856.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	\$ 17,856.00	Rent - Real Estate Tax on associated landowner (Pg 6)
39		(6,556.69)	PT, OT, ST CPT Therapy Costs
	10A	6,556.69	PT, OT, ST CPT Therapy Costs
30		\$ (483.00)	Reclass Depr on Painting
	6	\$ 483.00	Reclass Depr on Painting
		\$ -	

Facility Name & ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(800)	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	(1,928)	21		17
18	Fines and Penalties	(306)	32		18
19	Entertainment				19
20	Contributions	(3,904)	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	(705)	27		24
25	Fund Raising, Advertising and Promotional	(829)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (8,472)		\$	30

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	2	
		Amount	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)	23,573		34
35	Other- Attach Schedule	(10,358)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 13,215		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 4,743		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Alden Trails

ID# 0042051

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (1,365)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(4,530)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	542	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	7,103	6	4
5	Reconcile Depreciation expense	(1,550)	30	5
6	Elim ABC Deprec Exp from Pg 12 series -	54	30	6
7	Late Fees on Utilities	(458)	5	7
8	Intercompany Interest	(10,126)	32	8
9	Other nursing income - flu shots	(28)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	<b>Total</b>		(10,358)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	311	(1,555)	0	0	0	0	0	0	0	(1,244)	1
2	Food Purchase	0	0	0	(3,860)	0	0	0	0	0	0	0	(3,860)	2
3	Housekeeping	0	0	1,042	0	0	0	0	0	0	0	0	1,042	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(458)	0	386	0	0	0	0	0	0	0	0	(72)	5
6	Maintenance	6,845	0	279	0	0	0	(10)	0	0	0	0	7,114	6
7	Other (specify):*	0	0	948	335	0	0	0	0	0	0	0	1,283	7
8	<b>TOTAL General Services</b>	<b>6,387</b>	<b>0</b>	<b>2,966</b>	<b>(5,080)</b>	<b>0</b>	<b>0</b>	<b>(10)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,263</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,896	(3)	(314)	0	0	0	0	0	0	5,579	10
10a	Therapy	0	0	0	0	0	832	0	0	0	0	0	832	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	912	0	0	0	0	0	0	0	0	912	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>6,808</b>	<b>(3)</b>	<b>(314)</b>	<b>832</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,323</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	22,118	0	0	0	0	0	0	0	0	22,118	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,583	(67,384)	0	0	0	0	0	0	0	0	(64,801)	19
20	Fees, Subscriptions & Promotions	(4,733)	0	459	0	0	0	0	0	0	0	0	(4,274)	20
21	Clerical & General Office Expenses	(1,956)	103	33,725	8,842	387	0	0	0	0	0	0	41,101	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	193	0	0	0	0	0	0	0	0	193	24
25	Other Admin. Staff Transportation	0	0	1,856	0	0	0	0	0	0	0	0	1,856	25
26	Insurance-Prop.Liab.Malpractice	0	1,758	26	0	0	0	0	0	0	0	0	1,784	26
27	Other (specify):*	(705)	0	7,244	869	(7)	0	0	0	0	0	0	7,401	27
28	<b>TOTAL General Administration</b>	<b>(7,394)</b>	<b>4,444</b>	<b>(1,763)</b>	<b>9,711</b>	<b>380</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,378</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,007)</b>	<b>4,444</b>	<b>8,011</b>	<b>4,628</b>	<b>66</b>	<b>832</b>	<b>(10)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16,964</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(7,391)	41,082	3,990	0	0	0	0	0	0	0	0	37,681	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,432)	17,775	11,089	0	8	0	0	0	0	0	0	18,440	32
33	Real Estate Taxes	0	21,406	654	0	(1)	0	0	0	0	0	0	22,059	33
34	Rent-Facility & Grounds	0	(77,610)	0	0	0	0	0	0	0	0	0	(77,610)	34
35	Rent-Equipment & Vehicles	0	0	6,123	0	0	0	0	0	0	0	0	6,123	35
36	Other (specify):*	0	5,868	0	0	0	0	0	0	0	0	0	5,868	36
37	<b>TOTAL Ownership</b>	<b>(17,823)</b>	<b>8,521</b>	<b>21,856</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,561</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(24,368)	(414)	0	0	0	0	0	0	(24,782)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(24,368)</b>	<b>(414)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(24,782)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(18,830)	12,965	29,867	(19,740)	(341)	832	(10)	0	0	0	0	4,743	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	\$ 77,610	Alden of Bloomingdale Limited Partnership	0.00%	\$	\$ (77,610)	1
2	V	32 Interest Income - RR	22	Alden of Bloomingdale Limited Partnership			(22)	2
3	V	32 Interest Income	13,371	Alden of Bloomingdale Limited Partnership			(13,371)	3
4	V	21 Corporate Annual Report Fee		Alden of Bloomingdale Limited Partnership		103	103	4
5	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,583	2,583	5
6	V	6 Repairs & Maint./ R&M- RR		Alden of Bloomingdale Limited Partnership				6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		21,406	21,406	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,758	1,758	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		5,868	5,868	9
10	V	32 Interest - Mortgage/ IOD		Alden of Bloomingdale Limited Partnership		29,341	29,341	10
11	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership				11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		41,082	41,082	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		1,827	1,827	13
14	Total		\$ 91,003			\$ 103,968	\$ * 12,965	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%	\$ 386	\$	386	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		193		193	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,856		1,856	17
18	V	26 Insurance		Alden Management Services, Inc.		26		26	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		459		459	19
20	V	30 Depreciation		Alden Management Services, Inc.		3,990		3,990	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		654		654	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		6,123		6,123	22
23	V	32 Interest		Alden Management Services, Inc.		11,089		11,089	23
24	V	1 Dietary		Alden Management Services, Inc.		311		311	24
25	V	3 Houskeeping		Alden Management Services, Inc.		1,042		1,042	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		948		948	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		5,896		5,896	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		912		912	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		22,118		22,118	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		7,244		7,244	30
31	V	19 Professional Fees	82,249	Alden Management Services, Inc.		14,865		(67,384)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		33,725		33,725	32
33	V	6 Repairs & Maintenance	8,545	Alden Management Services, Inc.		8,824		279	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 90,794			\$ 120,661	\$ *	29,867	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	\$ 3,000	Prism Health Care Services, Inc.	0.00%	\$ 7	\$ (2,993)
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		1,438	1,438
17	V	2 Tube Feeding	5,686	Prism Health Care Services, Inc.		1,826	(3,860)
18	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		357	(3)
19	V	39 Ancillary Supplies	37,647	Prism Health Care Services, Inc.		13,279	(24,368)
20	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		5,227	5,227
21	V	27 Employee Benefits		Prism Health Care Services, Inc.		869	869
22	V	7 Employee Benefits		Prism Health Care Services, Inc.		335	335
23	V	21 General & Administrative		Prism Health Care Services, Inc.		3,615	3,615
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		\$ 46,693			\$ 26,953	\$ * (19,740)

\* 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	\$ 1,276	Forum Extended Care Services II, Inc.	0.00%	\$ 1,081	\$ (195)
16	V	39 IV		Forum Extended Care Services, Inc.			
17	V	39 Wound Care	1,431	Forum Extended Care Services, Inc.		1,212	(219)
18	V	10 House Stock	1,669	Forum Extended Care Services, Inc.		1,414	(255)
19	V	10 Pharmacy Consultant	384	Forum Extended Care Services, Inc.		325	(59)
20	V	27 Employee Vaccination	250	Forum Extended Care Services, Inc.		211	(39)
21	V	27 Employee Benefit: G & A		Forum Extended Care Services, Inc.		32	32
22	V	21 Salary: G & A		Forum Extended Care Services, Inc.		213	213
23	V	21 General and Administrative		Forum Extended Care Services, Inc.		174	174
24	V	32 Interest		Forum Extended Care Services, Inc.		8	8
25	V	33 Real Estate Tax		Forum Extended Care Services, Inc.		(1)	(1)
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		\$ 5,010			\$ 4,669	\$ * (341)

\* 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	\$ 6,557	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 7,389	\$ 832	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		\$ 6,557			\$ 7,389	\$ *	832	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repair & Maintenance	\$ 5,098	Alden Bennett Construction Company, Inc.	0.00%	\$ 5,088	\$	(10)	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	<b>Total</b>		\$ 5,098			\$ 5,088	\$ *	(10)	39

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

Facility Name &amp; ID Number

Alden Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	Alden Management Se	Chicago	Management	4
5			Alden of Old Town East, Inc.	Bloomingtondale				5
6			Alden Terrace of McHenry Rehabilitation and F	McHenry	Alden Gardens of Bloo	Bloomingtondale	Supportive Living F	6
7			Alden - Wentworth Rehabilitation and Health C	Chicago	Alden Garden Courts	DesPlaines	Assisted Living/Alz	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health	Bloomingtondale	Alden Gardens of Wat	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingtondale	Prism Health Care Ser	Schaumburg	Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health	Orland Park	Community Physical T	Addison	Therapy Provider	11
12			Alden - Princeton Rehabilitation and Health Ca	Chicago	Alden Bennett Constr	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipme	Fort Atkinson, WI	Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, I	Chicago	Design & Engineeri	14
15			Alden Trails, Inc.	Bloomingtondale	Achieve Recovery and	Elmhurst	Rehab-substance ab	15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for S	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health C	Skokie	Family Home Health S	Addison	Home health & hosj	17
18			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				18
19			Alden Estates of Evanston, Inc.	Evanston				19
20			Alden - Alma Nelson Manor, Inc.	Rockford				20
21			Alden - Park Strathmoor, Inc.	Rockford				21
22			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				22
23			Alden Estates of Barrington, Inc.	Barrington				23
24			Alden of Waterford, LLC	Aurora				24
25			Alden Springs, Inc.	Bloomingtondale				25
26			Alden Village North, Inc.	Chicago				26
27			Alden Estates of Skokie, Inc.	Skokie				27
28			Alden Estates of Countryside, Inc.	Jefferson, WI				28
29			Alden Estates of Shorewood, Inc.	Shorewood, IL				29
30								30

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## 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	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Floyd A. Schlossberg A.	President	CEO	100.00	184,191	0.176	0.44	Salary	\$ 809	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	94,585	0.176	0.44	Salary	415	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	94,585	0.176	0.44	Salary	415	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	99,803	0.176	0.44	Salary	438	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	60,662	0.176	0.44	Salary	266	21-7	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	D. Ina Schlossberg is the wife of Floyd Schlossberg. Ina is on the Board of Directors and participates in the general operations of the company.										10
11	E. Audra Elisco is the daughter of Floyd Schlossberg. Audra is a training coordinator for our Quality Assurance Program.										11
12											12
13								TOTAL	\$ 2,343		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 Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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

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

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

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	1,278,025	35	\$ 88,281	\$ 5,586	\$ 386	1	
2	24	Trav & Seminar	Patient Days	1,278,025	35	44,237	5,586	193	2	
3	25	Other Admin Travel	Patient Days	1,278,025	35	424,738	5,586	1,856	3	
4	26	Insurance	Patient Days	1,278,025	35	6,060	5,586	26	4	
5	20	Dues & Subscriptions	Patient Days	1,278,025	35	104,997	5,586	459	5	
6	30	Depreciation	No of Providers/usage	35	35	150,051	1	3,990	6	
7	33	Real Estate Tax	Patient Days/usage	1,278,025	35	171,564	5,586	654	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,278,025	35	1,400,909	5,586	6,123	8	
9	32	Interest	Patient Days/usage	1,278,025	35	2,235,440	5,586	11,089	9	
10	1	Dietary Salary	Patient Days	1,278,025	35	71,149	71,149	5,586	311	10
11	3	Housekeeping Salary	Patient Days	1,278,025	35	238,482	238,482	5,586	1,042	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,278,025	35	216,885	5,586	948	12	
13	10	Nurs & Med Records Salary	Patient Days/usage	1,278,025	35	1,414,605	1,414,605	5,586	5,896	13
14	15	Employee Benefits -Health Care	Patient Days	1,278,025	35	208,622	5,586	912	14	
15	17	Administrative Salary	Patient Days/usage	1,278,025	35	3,718,414	3,718,414	5,586	22,118	15
16	27	Employee Benefits - Admin	Patient Days	1,278,025	35	1,657,386	5,586	7,244	16	
17	19	Professional fees	Charge/usage	1,278,025	35	1,311,498	850,594	5,586	14,865	17
18	21	Gen'I & Admin	Patient Days/usage	1,278,025	35	7,716,027	6,669,245	5,586	33,725	18
19	6	Repair & Maint.	Charge/usage	1,278,025	35	1,444,891	1,161,005	5,586	8,824	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 22,624,236	\$ 14,123,494	\$ 120,661	25	

Facility Name & ID Number

Alden Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Cambridge		X	Mortgage	\$4,317.00	9/01/12	\$ 1,212,967	\$ 1,163,303	12/31/2047	2.5000	\$ 29,341	1						
2												2						
3												3						
4												4						
5	Amort of Fin Fees (GL 7105)		X	Refinancing							1,826	5						
<b>Working Capital</b>																		
6	Related party-AMS		X	Working Capital							11,089	6						
7	Related party-FECII		X	Working Capital							8	7						
8	Insurance Interest (GL 7053)		X	Medical Malpractice							275	8						
9	<b>TOTAL Facility Related</b>				<b>\$4,317.00</b>		<b>\$ 1,212,967</b>	<b>\$ 1,163,303</b>			<b>\$ 42,539</b>	<b>9</b>						
<b>B. Non-Facility Related*</b>																		
10	Interest Income on R.R.		X								(22)	10						
11	Int Income (GL#4975)		X									11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>(22)</b>	<b>14</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 1,212,967</b>	<b>\$ 1,163,303</b>			<b>\$ 42,517</b>	<b>15</b>						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,868 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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>19,861</u>	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.)		\$	<u>20,337</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>476</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>20,930</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>21,406</u>	7	
Real Estate Tax History:			Plus: Related Party Taxes (2) - See Pg RE_Tax	\$	<u>653.00</u>
			Total Real Estate Tax Expense, Sch V, Line 33	\$	<u>22,059</u>
Real Estate Tax Bill for Calendar Year:	2009	<u>16,202</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>16,663</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>18,248</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>18,899</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>20,337</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>The current year accrual is based on an estimated 3% increase of the prior year tax</b>					

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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Trails COUNTY DuPage  
 FACILITY IDPH LICENSE NUMBER 0042051  
 CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll  
 TELEPHONE 773-286-3883 FAX #: 773-286-8038

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(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</u>	\$ <u>317,349.00</u>	\$ <u>654.00</u>
2. <u>See attached (Supplement)</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>(9,166.00)</u>	\$ <u>(1.00)</u>
3. <u>02-23-301-016</u>	<u>Nursing Home Facility</u>	\$ <u>20,337.08</u>	\$ <u>20,337.08</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>328,520.08</u></u>	\$ <u><u>20,990.08</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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 Trails

# 0042051 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 6,610 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).  
none

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>nursing facility</u>	<u>38,474</u>	<u>1995</u>	<u>\$ 147,679</u>	1
2					2
3	<b>TOTALS</b>	<b>38,474</b>		<b>\$ 147,679</b>	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	\$	\$ 386,255
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	2 TV Modules		1999	1,775		5			1,775
10	Sprinkler System		1999	1,690	17	15	17		1,690
11	Replace heads-Irrigation system		1998	1,653		15			1,653
12	Carpentry, Ceramic,Quarry, Corain tops		2003	14,274	714	20	714	0	8,568
13	Panels		2003	5,175		5			5,175
14	Replaced Floor Tile		2006	2,730	273	10	273		2,411
15	New Sidewalk Ramp Railing-ABC		2008	3,722	248	15	248		1,829
16	Install Automatic Doors-ABC		2008	5,909	591	10	591		3,743
17	Sealcoat Parking Lot - ABC		2009	4,981	623	8	623		3,426
18									
19	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC		2011	11,117	556	20	556		2,085
20	Asphalt removal & replacement sealcoating marking restripe-ROSPA		2011	6,637	830	8	830		2,697
21	Valve maintenance/install stocked spare head cabinet - USFIRE		2011	2,500	500	5	500		1,500
22									
23	ABC - Repair pump/plugged w/ debris, not working		2012	4,819	482	10	482		1,406
24	ABC - Replace septic tank pumps		2012	6,829	683	10	683		1,423
25									
26									
27									
28									
29									
30	Adj for ABC related party profit		2008	(55)	(6)		(6)		(36)
31	Adj for ABC related party profit		2009	(66)	(8)		(8)		(44)
32	Adj for ABC related party profit		2011	86	6		6		21
33	Adj for ABC related party profit		2012	719	62		62		155
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 &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,009,357	\$ 28,943		\$ 28,943	\$ 0	\$ 425,732	1
2	Forum Prof Ctr: Remodeling	1979	15,638		20			15,057	2
3	Forum Prof Ctr: Build Improv - multiple	1980	30,456		15			29,324	3
4	Forum Prof Ctr: Tennant Improv	1986	961		13			925	4
5	Forum Prof Ctr: AMS remodel	1990	6,532		10			6,289	5
6	Forum Prof Ctr: Roof	1994	3,445		16			3,317	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,215		16			1,170	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,919	15	10	15		1,915	8
9	Forum Prof Ctr: Remodel/electrical	2001	747	14	7	14		734	9
10	Forum Prof Ctr: bathroom remodel	2002	661		5			661	10
11	Forum Prof Ctr: remodel suites/etc.	2003	850		9			850	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,616	79	7	79		2,555	12
13	Forum Prof Ctr: Suite renovation	2005	528	(13)	10	(13)		587	13
14	Forum Prof Ctr: Superior installations, etc.	2006	126		4			126	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	508	48	7	48		508	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	436	50	7	50		398	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	887	85	10	85		445	17
18	Forum Prof Ctr: Building Renovations	2010	1,511	267	5	267		1,276	18
19	Forum Prof Ctr: Building Renovations	2011	6,625	656	10	656		2,163	19
20	Forum Prof Ctr: Building Renovations	2012	288	39	15	39		117	20
21	Forum Prof Ctr: Building Renovations	2013	432	26	7	26		51	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	440	12		12		12	22
23	Alden Mgt Servs: Remodel suites	1993	6,963		10			6,963	23
24	Alden Mgt Servs: Remodel suites	2002	290	4	13	4		286	24
25	Alden Mgt Servs: Remodel suites	2003	6,295	12	11	12		6,295	25
26	Alden Mgt Servs: Motor Controller PC Board	2014	86	10		10		10	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,099,812	\$ 30,247		\$ 30,247	\$ 0	\$ 507,766	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	\$ 96,949	\$ 13,227	\$ 13,227	\$	varies	\$ 49,903	71
72	Current Year Purchases	10,529	920	920		varies	885	72
73	Fully Depreciated Assets	191,479	838	838		varies	191,479	73
74								74
75	TOTALS	\$ 298,957	\$ 14,985	\$ 14,985	\$		\$ 242,267	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	related party-AMS	various	1998-2004	4,026				3	4,026	77
78	Bus	2001 - Bus Midwest Transit	2001	16,646				5	16,646	78
79	transport	Bus	2000 & 2003	6,558				3	6,558	79
80	TOTALS			\$ 27,230	\$	\$	\$		\$ 27,230	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)	\$ 1,573,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,232	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,232	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 777,263	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	Fire Protection System	\$ 8,633	92
93			93
94			94
95		\$ 8,633	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 Trails

# 0042051

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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

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. 12/31/2015 \$ varies

13. 12/31/2016 \$ varies

14. 12/31/2017 \$ varies

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: \$ 6,649 Description: copy machine GL 6861-\$6364.08 and equipment lease GL 6859-\$285.23

(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>187.58</u>	\$ <u>2,251</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>187.58</u>	\$ <u>2,251</u>	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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	See Pg 16A	# of prescrpts				1,081		1,081	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):	39-1, 39-3, if any								12	
13	Other (specify):	See Pg 16A					14,491		14,491	13	
14	TOTAL			\$		\$	\$ 15,573		\$ 15,573	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		\$0.00	
2.	ST		39-3	To Col 5		0.00	
3.							
4.	PT		39-3	To Col 5		0.00	
5.							
6.							
7.							
8.							
	Pharmacy Supplies per GL					1,276.35	
	Manual Input from Related Party- Forum Drugs					(195.00)	
9.	Total to line 9 Pharmacy	See Pg 16A		To Col 6		1,081.35	1,081.35
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	0.00
13.	Other:	See Pg 16A					

13. Col 5: Manual Input: Related Party - CPT	To Col 5		0.00
Other		39,078.26	
Manual Input: Related Party - Prism		(24,368.00)	
Manual Input: Related Party FECII - I.V.			
Manual Input: Related Party FECII - Wound Care		(219.00)	
Oxygen, from reclass worksheet (Pg 4A)		0.00	
Transport Specialist		0.00	
13. Col 6: Supplies Total	To Col 6	14,491.26	14,491.26
13. Total Line 13, Column 8		0.00	14,491.26
14. Total		0.00	15,572.61

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,705 )	239,094	239,094	3
4	Supply Inventory (priced at )	610	610	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,893	6
7	Other Prepaid Expenses	2,004	2,004	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 241,708	\$ 247,601	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,679	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	38,959	56,074	15
16	Equipment, at Historical Cost	97,313	295,059	16
17	Accumulated Depreciation (book methods)	(100,491)	(622,280)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		19,122	21
22	Other Long-Term Assets (spec Refinancing fees)	1,383	35,339	22
23	Other(specify): Due from Affiliates	674,117	890,908	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 711,281	\$ 1,756,762	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 952,989	\$ 2,004,363	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 166,926	\$ 154,441	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,674	2,674	28
29	Short-Term Notes Payable		22,984	29
30	Accrued Salaries Payable	56,909	56,909	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,165	2,165	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,930	32
33	Accrued Interest Payable	1,105	2,424	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accr Exp/Ins,d/t PA,SaleTx,etc.	12,793	20,043	36
37	Due to Affiliates	124,916	124,916	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 367,488	\$ 407,486	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,140,319	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,140,319	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 367,488	\$ 1,547,805	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 585,501	\$ 456,558	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 952,989	\$ 2,004,363	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 768,149	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded		3
4	after prior year report submitted:	(92,330)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 675,819	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(90,318)	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)	\$ (90,318)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 585,501	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,170,529	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,170,529	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	28	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 28	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See page 19A, if any	258,951	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 258,951	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,429,508	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	229,906	31
32	Health Care	525,905	32
33	General Administration	266,607	33
<b>B. Capital Expense</b>			
34	Ownership	116,085	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	311,761	35
36	Provider Participation Fee	69,562	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,519,826	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(90,318)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (90,318)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,170,529	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice/Insurance</u>		47
48	Other-(specify) <u>Veterans/Sales Allow.</u>		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,170,529	49

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/2014 Ending:

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
<b>Misc. Income GL#4977 (discribe) (is offset against Sch.# V)</b>	
Day Training Income	\$ 258,453
Gain on Sale of Assets	\$ 498

Line 28 Total: 258,951



Facility Name & ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	2,688	2,806	107,160	38.19	3
4	Licensed Practical Nurses	2,151	2,443	66,119	27.06	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	520	520	10,609	20.40	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,624	4,624	62,229	13.46	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,448	1,515	21,217	14.00	18
19	Laundry					19
20	Administrator	440	440	14,650	33.30	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)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	23,154	24,741	308,411	12.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transport. Special</u>	384	401	6,396	15.95	33
34	TOTAL (lines 1 - 33)	35,409	37,490	\$ 596,791 *	\$ 15.92	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	250/month	\$ 3,000	1-3	35
36	Medical Director	425/month	5,100	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				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	4	220	11-3	44
45	Social Service Consultant	6	420	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	10	\$ 9,124		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	6	84	10-3	52
53	TOTAL (lines 50 - 52)	6	\$ 84		53







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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	Painting	09/14	4,344	3							483	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 4,344		\$	\$	\$	\$	\$	\$	\$ 483	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? HAB:Yes;RN/LPN:NO
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Health Care Coun. Of ILL dues \$883
- (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. \$ 8,401 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. n/a
- (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. \$ 69,562  
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. \$ 8,910 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.