

Facility Name & ID Number Alden Springs

0047191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	5,588			5,588	13
14	TOTALS	5,588			5,588	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

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

123 (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 10/13/06

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: 12/31/15 Fiscal Year: 12/31/15

* 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
	A. General Services										
1	Dietary	62,028	3,544	3,600	69,172	831	70,003	(655)	69,348		1
2	Food Purchase		46,511		46,511	(3,525)	42,986	(1,490)	41,496		2
3	Housekeeping	15,920	4,824		20,744		20,744	1,084	21,828		3
4	Laundry		4,475		4,475		4,475		4,475		4
5	Heat and Other Utilities			23,595	23,595		23,595	(138)	23,457		5
6	Maintenance	9,054	224	46,582	55,860		55,860	6,168	62,028		6
7	Other (specify):* related party							970	970		7
8	TOTAL General Services	87,002	59,578	73,777	220,357	(2,694)	217,663	5,939	223,602		8
	B. Health Care and Programs										
9	Medical Director			3,725	3,725		3,725		3,725		9
10	Nursing and Medical Records	417,882	29,601	964	448,447	676	449,123	6,840	455,963		10
10a	Therapy		69	5,151	5,220		5,220	941	6,161		10a
11	Activities	16,983		640	17,623		17,623		17,623		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							974	974		15
16	TOTAL Health Care and Programs	434,865	29,670	10,480	475,015	676	475,691	8,755	484,446		16
	C. General Administration										
17	Administrative	19,199			19,199		19,199	17,367	36,566		17
18	Directors Fees										18
19	Professional Services			88,347	88,347		88,347	(63,516)	24,831		19
20	Dues, Fees, Subscriptions & Promotions			3,586	3,586		3,586	(629)	2,957		20
21	Clerical & General Office Expenses	25,060	2,612	19,171	46,843		46,843	31,954	78,797		21
22	Employee Benefits & Payroll Taxes			101,167	101,167	2,018	103,185	(1,031)	102,154		22
23	Inservice Training & Education										23
24	Travel and Seminar			71	71		71	144	215		24
25	Other Admin. Staff Transportation			571	571		571	1,676	2,247		25
26	Insurance-Prop.Liab.Malpractice			20,072	20,072		20,072	2,128	22,200		26
27	Other (specify):* related party			1,107	1,107		1,107	6,368	7,475		27
28	TOTAL General Administration	44,259	2,612	234,092	280,963	2,018	282,981	(5,539)	277,442		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	566,126	91,860	318,349	976,335		976,335	9,155	985,490		29

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

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

Facility Name & ID Number Alden Springs

#0047191

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
	D. Ownership											
30	Depreciation			15,150	15,150		15,150	54,280	69,430			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,838	6,838		6,838	58,262	65,100			32
33	Real Estate Taxes			33,927	33,927	(33,927)		34,613	34,613			33
34	Rent-Facility & Grounds			115,754	115,754	33,927	149,681	(149,681)				34
35	Rent-Equipment & Vehicles			3,241	3,241		3,241	5,584	8,825			35
36	Other (specify):*											36
37	TOTAL Ownership			174,910	174,910		174,910	3,058	177,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,985		27,985		27,985	(8,069)	19,916			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,984	70,984		70,984		70,984			42
43	Other (specify):* DT/Trans. Specialist			255,419	255,419		255,419		255,419			43
44	TOTAL Special Cost Centers		27,985	326,403	354,388		354,388	(8,069)	346,319			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	566,126	119,845	819,662	1,505,633		1,505,633	4,144	1,509,777			45

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

Alden Springs
 Period Beginning: 01/01/2015
 Period Ending: 12/31/2015

IDPH License No. 0047191

Page 4A

Reclassifications - Pages 3 & 4

From Line	To Line	Amount	Description
2		(3,525.00)	Employee Meals
	22	3,525.00	Employee Meals
22		\$ (1,507.00)	Uniform Reclass
	1	\$ 831.00	Uniform Reclass
	3		Uniform Reclass
	4		Uniform Reclass
	6		Uniform Reclass
	10	\$ 676.00	Uniform Reclass
	11		Uniform Reclass
	21		Uniform Reclass
33		(33,927.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	33,927.00	Rent - Real Estate Tax on associated landowner (Pg 6)
Net (Should be zero)		\$ -	

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	(2,086)	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	(23,336)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,991)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(330)	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	(1,107)	27		24
25	Fund Raising, Advertising and Promotional	(1,056)	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)	\$ (29,906)		\$	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	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)	59,567		34
35	Other- Attach Schedule	(25,517)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,050		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,144		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	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Springs

ID# 0047191

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Late Fees on Utilities	\$ (564)	5	1
2	Employee Flu Shots	(41)	21	2
3	Intercompany Interest Not allowed (GL#7031)	(6,565)	32	3
4	Elim. Land Owner bank charges	(5)	19	4
5	Gain/Loss on FMV of Swap	(19,613)	32	5
6	Elim Deprec Exp on Pg 13 items under \$2500	(3,310)	30	6
7	Expense Pg 13 items < \$2,500 Curr Yr	5,721	6	7
8	Elim Deprec on Pg 12 < \$2,500 items	(42)	30	8
9	AMS depreciation Adjustments	(241)	30	9
10	Adj YTD Deprec Exp to Detail	(857)	30	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
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		(25,517)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	326	(981)	0	0	0	0	0	0	0	(655)	1
2	Food Purchase	0	0	0	(1,490)	0	0	0	0	0	0	0	(1,490)	2
3	Housekeeping	0	0	1,084	0	0	0	0	0	0	0	0	1,084	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(564)	0	426	0	0	0	0	0	0	0	0	(138)	5
6	Maintenance	3,635	0	2,524	0	0	0	(5)	14	0	0	0	6,168	6
7	Other (specify):*	0	0	970	0	0	0	0	0	0	0	0	970	7
8	TOTAL General Services	3,071	0	5,330	(2,471)	0	0	(5)	14	0	0	0	5,939	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	6,141	780	(81)	0	0	0	0	0	0	6,840	10
10a	Therapy	0	0	0	0	0	941	0	0	0	0	0	941	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	974	0	0	0	0	0	0	0	0	974	15
16	TOTAL Health Care and Programs	0	0	7,115	780	(81)	941	0	0	0	0	0	8,755	16
	C. General Administration													
17	Administrative	0	0	17,367	0	0	0	0	0	0	0	0	17,367	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5)	5	(63,516)	0	0	0	0	0	0	0	0	(63,516)	19
20	Fees, Subscriptions & Promotions	(1,386)	250	507	0	0	0	0	0	0	0	0	(629)	20
21	Clerical & General Office Expenses	(2,032)	0	33,986	0	0	0	0	0	0	0	0	31,954	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(1,031)	0	0	0	0	0	0	(1,031)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	144	0	0	0	0	0	0	0	0	144	24
25	Other Admin. Staff Transportation	0	0	1,676	0	0	0	0	0	0	0	0	1,676	25
26	Insurance-Prop.Liab.Malpractice	0	2,097	31	0	0	0	0	0	0	0	0	2,128	26
27	Other (specify):*	(1,107)	0	7,475	0	0	0	0	0	0	0	0	6,368	27
28	TOTAL General Administration	(4,530)	2,352	(2,330)	0	(1,031)	0	0	0	0	0	0	(5,539)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,459)	2,352	10,115	(1,691)	(1,112)	941	(5)	14	0	0	0	9,155	29

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs# 0047191

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(4,450)	54,526	4,204	0	0	0	0	0	0	0	0	54,280	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,514)	100,308	7,468	0	0	0	0	0	0	0	0	58,262	32
33	Real Estate Taxes	0	33,927	686	0	0	0	0	0	0	0	0	34,613	33
34	Rent-Facility & Grounds	0	(149,681)	0	0	0	0	0	0	0	0	0	(149,681)	34
35	Rent-Equipment & Vehicles	0	0	5,584	0	0	0	0	0	0	0	0	5,584	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53,964)	39,080	17,942	0	0	0	0	0	0	0	0	3,058	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	(8,946)	877	0	0	0	0	0	0	(8,069)	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	(8,946)	877	0	0	0	0	0	0	(8,069)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,423)	41,432	28,057	(10,637)	(235)	941	(5)	14	0	0	0	4,144	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 PG 6-Supp		See PG 6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 149,681	Alden Trails II, LLC	0.00%	\$	\$ (149,681)	1
2	V	6 Repairs & Maintenance		Alden Trails II, LLC				2
3	V	19 Bank Charges		Alden Trails II, LLC		5	5	3
4	V	33 Real Estate Tax Expense		Alden Trails II, LLC		33,927	33,927	4
5	V	26 General Insurance Expense		Alden Trails II, LLC		2,097	2,097	5
6	V	32 Interest - Mortgage		Alden Trails II, LLC		79,225	79,225	6
7	V	30 Depreciation		Alden Trails II, LLC		54,526	54,526	7
8	V	21 Miscellaneous Costs		Alden Trails II, LLC				8
9	V	20 Corporate Annual Report Fee		Alden Trails II, LLC		250	250	9
10	V	19 Professional Fees		Alden Trails II, LLC				10
11	V	32 Amortization Expense		Alden Trails II, LLC		1,470	1,470	11
12	V	32 Gain/Loss on FMV of SWAP		Alden Trails II, LLC		19,613	19,613	12
13	V							13
14	Total		\$ 149,681			\$ 191,113	\$ * 41,432	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%	\$ 426	\$	426	15
16	V	24 Trav & Seminar		Alden Management Services, Inc.		144		144	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,676		1,676	17
18	V	26 Insurance		Alden Management Services, Inc.		31		31	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		507		507	19
20	V	30 Depreciation		Alden Management Services, Inc.		4,204		4,204	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		686		686	21
22	V	35 Rent-Equip & Vehicles		Alden Management Services, Inc.		5,584		5,584	22
23	V	32 Interest		Alden Management Services, Inc.		7,468		7,468	23
24	V	1 Dietary		Alden Management Services, Inc.		326		326	24
25	V	3 Housekeeping		Alden Management Services, Inc.		1,084		1,084	25
26	V	7 Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		970		970	26
27	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		6,141		6,141	27
28	V	15 Employee Benefits-Health Care		Alden Management Services, Inc.		974		974	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		17,367		17,367	29
30	V	27 Employee Benefits-Admin		Alden Management Services, Inc.		7,475		7,475	30
31	V	19 Professional Fees	78,615	Alden Management Services, Inc.		15,099		(63,516)	31
32	V	21 Gen'l & Admin		Alden Management Services, Inc.		33,986		33,986	32
33	V	6 Repair & Maint	3,578	Alden Management Services, Inc.		6,102		2,524	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 82,193			\$ 110,250	\$ *	28,057	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 Consult.	\$ 3,600	Prism Health Care Sevices, Inc.	0.00%	\$ 20	\$ (3,580)	15
16	V	1 Dietary Salary		Prism Health Care Sevices, Inc.		1,804	1,804	16
17	V	2 Tube feeding	10,547	Prism Health Care Sevices, Inc.		6,535	(4,012)	17
18	V	10 Equip. Rental	360	Prism Health Care Sevices, Inc.		476	116	18
19	V	39 Ancillary supplies	24,609	Prism Health Care Sevices, Inc.		10,446	(14,163)	19
20	V	1 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		795	795	20
21	V	2 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		2,522	2,522	21
22	V	10 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		664	664	22
23	V	39 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		5,217	5,217	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		\$ 39,116			\$ 28,479	\$ * (10,637)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Drugs	\$ 2,684	Forum Extended Care Services II, Inc.	0.00%	\$ 2,590	\$ (94)
16	V	39 I.V.		Forum Extended Care Services II, Inc.			
17	V	39 Wound Care	692	Forum Extended Care Services II, Inc.		668	(24)
18	V	10 House Stock	1,951	Forum Extended Care Services II, Inc.		1,883	(68)
19	V	10 Pharm Consult	384	Forum Extended Care Services II, Inc.		371	(13)
20	V	22 Vaccinations	1,031	Forum Extended Care Services II, Inc.			(1,031)
21	V	39 Vaccinations		Forum Extended Care Services II, Inc.		995	995
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,742			\$ 6,507	\$ * (235)

* 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	\$ 5,151	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 6,092	\$ 941	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		\$ 5,151			\$ 6,092	\$ *	941	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	\$ 2,593	Alden Bennett Construction Company, Inc.	0.00%	\$ 2,588	\$	(5) 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		\$ 2,593			\$ 2,588	\$ *	(5) 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	\$ 66	Alden Design Group, Inc.	0.00%	\$ 80	\$	14	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		\$ 66			\$ 80	\$ *	14	39

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

Facility Name & ID Number

Alden Springs

0047191

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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 Springs # 0047191 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg A.	President	CEO	100.00	184,174	0.18	0.45	Salary	\$ 826	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,554	0.18	0.45	Salary	446	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,554	0.18	0.45	Salary	446	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	108,661	0.18	0.45	Salary	487	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	62,237	0.18	0.45	Salary	279	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	\$ 2,484		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

01/01/2015

Ending: 2/31/2015

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	34	\$ 95,438	\$	5,588	\$ 426	1
2	24	Travel & Seminar	Patient days	34	32,213		5,588	144	2
3	25	Other Admin Travel	Patient days	34	375,370		5,588	1,676	3
4	26	Insurance	Patient days	34	6,897		5,588	31	4
5	20	Dues/Subscriptions	Patient days	34	113,573		5,588	507	5
6	30	Depreciation	No. of providers	34	156,306		1	4,204	6
7	33	Real Estate Tax	Patient days/usage	34	176,959		5,588	686	7
8	35	Rent-Equip/Vehicles	Patient days	34	1,250,701		5,588	5,584	8
9	32	Interest	Patient days/usage	34	2,158,573		5,588	7,468	9
10	1	Dietary Aide Coordinator Salary	Patient days	34	72,994	72,994	5,588	326	10
11	3	Housekeeping Coordinator Salary	Patient days	34	242,795	242,795	5,588	1,084	11
12	7	Employee Benef % -Gen'l Servs	Patient days	34	217,281		5,588	970	12
13	10	Nurs/Med Records Salary	Patient days/usage	34	1,562,220	1,562,220	5,588	6,141	13
14	15	Employee Benef % - Health Care	Patient days	34	218,198		5,588	974	14
15	17	Administrative Salary	Patient days/usage	34	4,332,153	4,332,153	5,588	17,367	15
16	27	Employee Benef %-Administrativ	Patient days	34	1,674,148		5,588	7,475	16
17	19	Professional Fees	Patient days	34	1,213,223	909,774	5,588	15,099	17
18	21	Gen'l & Admin	Patient days/usage	34	7,611,926	6,744,406	5,588	33,986	18
19	6	Repairs & Maintenance	Patient days	34	1,835,211	1,239,870	5,588	6,102	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 23,346,179	\$ 15,104,212		\$ 110,250	25

Facility Name & ID Number

Alden Springs

0047191

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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						
			Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO										Original	Balance			
		A. Directly Facility Related																
		Long-Term																
1		MB Bank (GI 2513/2021/7055)		X	Mortgage	Varies	8/29/12	\$ 1,520,000	\$ 1,415,525	9/05/2022	3.5000	\$ 53,373	1					
2													2					
3		FMV of Derivative		X	Rate Swap interest							25,852	3					
4		Insurance Interest (GL 7053)		X	Medical Malpractice							273	4					
5		Amort of Fin Fees (GL 7105)		X	Refinancing							1,470	5					
		Working Capital																
6		Related party-AMS		X	Working Capital							7,468	6					
7													7					
8													8					
9		TOTAL Facility Related							\$ 1,520,000	\$ 1,415,525			\$ 88,436	9				
		B. Non-Facility Related*																
10		Int Income (GL#4975)		X								(23,336)	10					
11													11					
12													12					
13													13					
14		TOTAL Non-Facility Related							\$	\$			(23,336)	14				
15		TOTALS (line 9+line14)							\$ 1,520,000	\$ 1,415,525			\$ 65,100	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2014 report.	\$	<u>35,400</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>34,127</u>		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	<u>(1,273)</u>		3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>35,200</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. (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.	\$	<u>33,927</u>		7
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	<u>686</u>
		Total Real Estate Tax Expense, Sch V, Line 33		\$	<u>34,613</u>
Real Estate Tax Bill for Calendar Year:		2010	<u>28,181</u>	8	
		2011	<u>30,863</u>	9	
		2012	<u>31,963</u>	10	
		2013	<u>34,394</u>	11	
		2014	<u>34,127</u>	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 2014	\$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Springs COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0047191

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773)286-3883 FAX #: (773)286-8038

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>153,627.00</u>	\$ <u>686.00</u>
2. <u>02-23-300-024</u>	<u>Alden Trails II LLC</u>	\$ <u>34,126.82</u>	\$ <u>34,126.82</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>187,753.82</u></u>	\$ <u><u>34,812.82</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Alden Springs

0047191 Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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 (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>22,035</u>	<u>2006</u>	<u>\$ 398,630</u>	1
2					2
3	TOTALS	<u>22,035</u>		<u>\$ 398,630</u>	3

Facility Name & ID Number Alden Springs

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		2006	\$ 1,583,599	\$ 39,590	40	\$ 39,590	\$	\$ 366,207
5			2006	69,510	1,738	40	1,738		16,076
6			2006	20,156	504	40	504		4,872
7									
8									
Improvement Type**									
9	Wiring		2006	840	42	20	42		389
10									
11	Drywall Carpentry		2007	18,677	1,245	15	1,245		10,791
12	Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	2,313	10	2,313		20,815
13									
14									
15									
16									
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33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,715,910	\$ 45,432		\$ 45,432	\$	\$ 419,150	1
2	Forum Prof Ctr: Remodeling	1979	15,638		20			15,638	2
3	Forum Prof Ctr: Build Improv - multiple	1980	30,456		15			30,456	3
4	Forum Prof Ctr: Tennant Improv	1986	961		13			961	4
5	Forum Prof Ctr: AMS remodel	1990	6,532		10			6,532	5
6	Forum Prof Ctr: Roof	1994	3,445		16			3,445	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,215		16			1,215	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,919	4	10	4		1,919	8
9	Forum Prof Ctr: Remodel/electrical	2001	747	14	7	14		747	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	58	7	58		2,613	12
13	Forum Prof Ctr: Suite renovation	2005	528	(13)	10	(13)		574	13
14	Forum Prof Ctr: Superior installations, etc.	2006	126		4			126	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	508		7			508	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	436	38	7	38		436	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	887	86	10	86		531	17
18	Forum Prof Ctr: Building Renovations	2010	1,511	235	5	235		1,511	18
19	Forum Prof Ctr: Building Renovations	2011	6,625	633	10	633		2,796	19
20	Forum Prof Ctr: Building Renovations	2012	288	39	15	39		156	20
21	Forum Prof Ctr: Building Renovations	2013	432	62	7	62		113	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	440	44	10	44		56	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	455	51	15-Mar	51		51	23
24	Alden Mgt Servs: Remodel suites	1993	6,963		10			6,963	24
25	Alden Mgt Servs: Remodel suites	2002	290	4	13	4		290	25
26	Alden Mgt Servs: Remodel suites	2003	6,295		11			6,295	26
27	Alden Mgt Servs: Motor Controller PC Board	2014	86	17	5	17		27	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,806,820	\$ 46,704		\$ 46,704	\$	\$ 504,620	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	\$ 218,043	\$ 21,592	\$ 21,592	\$	varies	\$ 135,392	71
72	Current Year Purchases	3,384	1,029	1,029		varies	1,029	72
73	Fully Depreciated Assets	102,849	105	105		varies	102,849	73
74								74
75	TOTALS	\$ 324,276	\$ 22,726	\$ 22,726	\$		\$ 239,270	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										78
79										79
80	TOTALS			\$ 4,026	\$	\$	\$		\$ 4,026	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)	\$ 2,533,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,430	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,430	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)	\$ 747,916	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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 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. 12/31/2016 \$ varies

13. 12/31/2017 \$ varies

14. 12/31/2018 \$ 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: \$ 3,638 Description: <---copy machine gl 6861 & equip lease gl 6959

(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>143.67</u>	\$ <u>1,724</u>	17
18					18
19	<u>Auto lease - gl 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>143.67</u>	\$ <u>1,724</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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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				3,585		3,585	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					16,331		16,331	13	
14	TOTAL			\$		\$	\$ 19,916		\$ 19,916	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	Reclass on PG 4A PG16 FRX
2.	ST		39-3	To Col 5		0.00	Reclass on PG 4A PG16 FRX
3.							
4.	PT		39-3	To Col 5		0.00	Reclass on PG 4A PG16 FRX
5.							
6.							
7.							
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities					0.00	Reclass on PG 4A (None in 2
						<u>0.00</u>	
	Less: OT, ST, & PT costs - reclassified to 10A for DD facilities					<u>0.00</u>	
						0.00	
	Pharmacy Supplies per GL					2,683.75	
	Manual Input from Related Party- Forum Drugs & Vaccinations					901.00	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A		To Col 6		<u>3,584.75</u>	
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)					<u>0.00</u>	

13. Other: See Pg 16A

13. Col 5: Manual Input: Related Party - CPT To Col 5

Other	25,300.97	PG16 FRX
Manual Input: Related Party - Prism	(8,946.00)	From Page 6B
Manual Input: Related Party FECII - I.V.	0.00	From Page 6C
Manual Input: Related Party FECII - Wound Care Oxygen, from reclass worksheet (Pg 4A)	(24.00)	From Page 6C

13. Col 6: Supplies Total To Col 6 16,330.97

13. Total Line 13, Column 8 16,330.97

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 17,666	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	219,629	219,629	3
4	Supply Inventory (priced at)	561	561	4
5	Short-Term Investments			5
6	Prepaid Insurance		1,492	6
7	Other Prepaid Expenses	2,040	2,040	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	23,335	23,335	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 245,565	\$ 264,723	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	21,374	21,374	15
16	Equipment, at Historical Cost	108,583	293,732	16
17	Accumulated Depreciation (book methods)	(62,429)	(596,993)	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 (spec <u>(Refinan.Fee)</u>		9,915	22
23	Other(specify): <u>Due from Affiliate, Wage Allocat</u>	217,553	153,563	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 285,081	\$ 1,954,328	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 530,646	\$ 2,219,051	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 117,307	\$ 117,307	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	304	304	28
29	Short-Term Notes Payable		36,001	29
30	Accrued Salaries Payable	71,694	71,694	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,621	2,621	31
32	Accrued Real Estate Taxes(Sch.IX-B)		35,200	32
33	Accrued Interest Payable		6,655	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Exp/Ins,d/t PA,SaleTx,etc.</u>	37,793	37,793	36
37	<u>Due to Affiliates</u>	91,678	91,678	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 321,397	\$ 399,253	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,379,525	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to affiliates-Wage allocation</u>			43
44	<u>FMV of Derivative</u>		27,103	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,406,627	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 321,397	\$ 1,805,880	46
47	TOTAL EQUITY(page 18, line 24)	\$ 209,249	\$ 413,171	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 530,646	\$ 2,219,051	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 173,541	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 173,541	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(38,581)	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) <u>Prior years shared salaries</u>	74,289	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 35,708	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)	\$ 209,249	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,188,256	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,188,256	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	41	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	23,336	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,336	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training</u>	255,419	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 255,419	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,467,052	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	220,357	31
32	Health Care	475,015	32
33	General Administration	280,963	33
B. Capital Expense			
34	Ownership	174,910	34
C. Ancillary Expense			
35	Special Cost Centers	283,404	35
36	Provider Participation Fee	70,984	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,505,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(38,581)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (38,581)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,188,256	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,188,256	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.

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	1,962	2,072	81,630	39.41	3
4	Licensed Practical Nurses	3,017	3,173	83,043	26.18	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	464	464	9,772	21.06	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	106	107	2,683	25.07	13
14	Head Cook	4,522	4,522	59,345	13.12	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	520	520	9,054	17.41	17
18	Housekeepers	938	1,112	15,920	14.32	18
19	Laundry					19
20	Administrator	520	520	19,199	36.92	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)	19,305	20,949	253,209	12.09	30
31	Medical Records					31
32	Other Health C: Facility Manager	1,036	1,040	25,060	24.10	32
33	Other(specify) Behavioral Health	208	208	7,211	34.67	33
34	TOTAL (lines 1 - 33)	32,597	34,686	\$ 566,126 *	\$ 16.32	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	300/Monthly	\$ 3,600	1-3	35
36	Medical Director	310/Monthly	3,725	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	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	\$ 8,349		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			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nancy Rodriguez	Administrator	0	\$ 19,199	Workers' Compensation Insurance	\$ 22,166	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,485	Advertising: Employee Recruitment	74	
				FICA Taxes	45,714	Health Care Worker Background Check		
				Employee Health Insurance	24,542	(Indicate # of checks performed)		
				Employee Meals	3,525	Patient Background Checks	1 10	
				Illinois Municipal Retirement Fund (IMRF)*		Health care council of ILL	1,536	
				Dental/Life Insurance	350	Collaborative Healthcare	250	
				Employee Drug Tests	192	Citi/Secretary of State-Annual Report	405	
				Misc Payroll Costs/401K Match	1,123	Surety bond fees-Marsh USA Inc.	175	
				Employee Relations	1,057	Related Party-AMS	507	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 19,199	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 102,154		\$ 2,957		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Related Party-AMS	144
(Attach a copy of any management service agreement)							Seminar Expense	
							IL Council of Long Term Care	71
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 88,347				TOTAL	\$ 215
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Alden Springs
 Legal Fee Support
 2015

Legal Fees Reported on Pg 21, Section C:	23,344
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22	-
Non-allowable legal fees, if any, deducted on - Pg 6A (AMS Allocated Legal Fees)	(19,200)
+ Add Back voided invoice of prior year, if any	
Allowable Legal Fees	<u>4,144</u>

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
Medicaid Legal Fees	12/10/15	4,109
MIDCAP Allo.Legal Fees 01/15	01/31/15	5
MIDCAP Allo.Legal Fees 02/15	02/28/15	8
MIDCAP Allo.Legal Fees 03/15	03/31/15	41
MIDCAP Allo.Legal Fees 04/15	04/30/15	(49)
MIDCAP Allo.Legal Fees 10/15	10/31/15	31
TOTAL ALLOWABLE LEGAL FEES		<u><u>4,144</u></u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		<u><u>-</u></u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
AMS Legal exp Allocation 2015	1/1/2015	1,600
HFS 3745 (N-4-99)		

AMS Legal exp Allocation 2015	02/01/15	1,600
AMS Legal exp Allocation 2015	03/01/15	1,600
AMS Legal exp Allocation 2015	04/01/15	1,600
AMS Legal exp Allocation 2015	05/01/15	1,600
AMS Legal exp Allocation 2015	06/01/15	1,600
AMS Legal exp Allocation 2015	07/01/15	1,600
AMS Legal exp Allocation 2015	08/01/15	1,600
AMS Legal exp Allocation 2015	09/01/15	1,600
AMS Legal exp Allocation 2015	10/01/15	1,600
AMS Legal exp Allocation 2015	11/01/15	1,600
AMS Legal exp Allocation 2015	12/01/15	1,600

TOTAL Allocated Legal Fees	19,200
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Total Legal Cost	23,344
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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												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? C.N.A.-Yes, RN/LPNs-N (13)
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCC of Illinois \$1,536
- (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. \$ 8,859 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. \$ 70,984
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. \$ 3,525 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? No
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.