

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	96	Skilled (SNF)	96	35,040	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		ICF/DD 16 or Less		0	6
7	96	TOTALS	96	35,040	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	546	384	2,294	3,224	8
9	SNF/PED					9
10	ICF	23,210	2,420	2,871	28,501	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,756	2,804	5,165	31,725	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 1,721

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr # 0040709 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	228,086	16,670	26,400	271,156	1,793	272,949	(5,973)	266,976		1
2	Food Purchase		228,266		228,266	(31,439)	196,827	(12,634)	184,193		2
3	Housekeeping	167,201	31,586		198,787	566	199,353	5,243	204,596		3
4	Laundry	23,763	7,603		31,366	683	32,049		32,049		4
5	Heat and Other Utilities			113,040	113,040		113,040	686	113,726		5
6	Maintenance	48,054		118,145	166,199	237	166,436	29,457	195,893		6
7	Other (specify):* related party							5,755	5,755		7
8	TOTAL General Services	467,104	284,125	257,585	1,008,814	(28,160)	980,654	22,534	1,003,188		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,069,921	135,843	8,338	2,214,102	(387)	2,213,715	42,328	2,256,043		10
10a	Therapy		3,039	27,302	30,341		30,341		30,341		10a
11	Activities	75,252	4,263	4,270	83,785	151	83,936		83,936		11
12	Social Services	50,496			50,496		50,496		50,496		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							5,745	5,745		15
16	TOTAL Health Care and Programs	2,195,669	143,145	48,910	2,387,724	(236)	2,387,488	48,073	2,435,561		16
	C. General Administration										
17	Administrative	103,655			103,655		103,655	108,619	212,274		17
18	Directors Fees										18
19	Professional Services			552,196	552,196		552,196	(478,078)	74,118		19
20	Dues, Fees, Subscriptions & Promotions			109,567	109,567		109,567	(97,093)	12,474		20
21	Clerical & General Office Expenses	160,889	13,776	121,027	295,692	541	296,233	153,587	449,820		21
22	Employee Benefits & Payroll Taxes			520,238	520,238	21,521	541,759	(2,249)	539,510		22
23	Inservice Training & Education										23
24	Travel and Seminar							763	763		24
25	Other Admin. Staff Transportation			1,192	1,192		1,192	8,348	9,540		25
26	Insurance-Prop.Liab.Malpractice			152,076	152,076		152,076	177	152,253		26
27	Other (specify):* related party/Bad Debt			224,334	224,334		224,334	(179,628)	44,706		27
28	TOTAL General Administration	264,544	13,776	1,680,630	1,958,950	22,062	1,981,012	(485,554)	1,495,458		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,927,317	441,046	1,987,125	5,355,488	(6,334)	5,349,154	(414,947)	4,934,207		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 Lincoln Rehab & HC Ctr

#0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			72,197	72,197		72,197	(16,463)	55,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,540	47,540		47,540	(1,034)	46,506			32
33	Real Estate Taxes			134,334	134,334		134,334	2,532	136,866			33
34	Rent-Facility & Grounds			400,480	400,480		400,480		400,480			34
35	Rent-Equipment & Vehicles			10,553	10,553		10,553	22,868	33,421			35
36	Other (specify):* MIP											36
37	TOTAL Ownership			665,104	665,104		665,104	7,903	673,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		291,290	498,548	789,838	6,334	796,172	40,989	837,161			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,191	229,191		229,191		229,191			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		291,290	727,739	1,019,029	6,334	1,025,363	40,989	1,066,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,927,317	732,336	3,379,968	7,039,621		7,039,621	(366,055)	6,673,566			45

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

0040709
 Period Beginning: 01/01/2017
 Period Ending: 12/31/2017

IDPH License No. 0

Page 4A

Reclassifications - Pages 3 & 4

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(31,439)	Employee Meals
	22	31,439	Employee Meals
22		(9,918)	Uniform Reclass
	1	1,793	Uniform Reclass
	3	566	Uniform Reclass
	4	683	Uniform Reclass
	6	237	Uniform Reclass
	10	5,947	Uniform Reclass
	11	151	Uniform Reclass
	21	541	Uniform Reclass
10		(6,334)	Oxygen Cost Reclass
	39	6,334	Oxygen Cost Reclass

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	(3,408)	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	(7,235)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,152)	2		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	(13,050)	21		17
18	Fines and Penalties	(229)	32		18
19	Entertainment	(66)	20		19
20	Contributions	(3,907)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,290)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(224,334)	27		24
25	Fund Raising, Advertising and Promotional	(8,343)	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)	\$ (263,014)		\$	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)	(50,255)	Pg 6s	34
35	Other- Attach Schedule	(52,786)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (103,041)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (366,055)		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

BHF USE ONLY							
48		49		50		51	

Alden Lincoln Rehab & HC Ctr

ID# 0040709

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Elim Deprec Exp on Pg 12 <\$2,500	\$ (2,246)	30	1
2	Elim Deprec Exp on Pg 13 <\$2,500	(15,674)	30	2
3	Exp Pg12<\$2,500 - current year purch	2,113	6	3
4	Exp Pg13<\$2,500 - current year purch	12,553	6	4
5	Elim ABC Pg12-Related Party profit 2008-2016	(321)	30	5
6	Elim ABC Pg12-Related Party profit 2017	(1)	30	6
7	adj Depreciation exp	(1,003)	30	7
8				8
9	Late Fees on Utilities	(1,485)	5	9
10	Intercompany interests (MidCap	(45,642)	32	10
11	Misc Income - Medical Records	(207)	10	11
12	Misc Income - Jury Duty	(69)	21	12
13	Misc Income - Food Rebate	(769)	2	13
14	Misc Income - Poll site		21	14
15	Other Nursing Income: flu shots	(29)	21	15
16	add back prior year Real Estate Tax Refund		33	16
17	Vendor adjustment	(6)	2	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	(52,786)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	1,788	(7,761)	0	0	0	0	0	0	0	(5,973)	1
2	Food Purchase	(1,927)	0	0	(10,707)	0	0	0	0	0	0	0	(12,634)	2
3	Housekeeping	0	0	5,243	0	0	0	0	0	0	0	0	5,243	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,485)	0	2,171	0	0	0	0	0	0	0	0	686	5
6	Maintenance	11,258	0	17,042	0	0	0	(28)	1,185	0	0	0	29,457	6
7	Other (specify):*	0	0	5,755	0	0	0	0	0	0	0	0	5,755	7
8	TOTAL General Services	7,846	0	31,999	(18,468)	0	0	(28)	1,185	0	0	0	22,534	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	(207)	0	37,712	6,024	(1,201)	0	0	0	0	0	0	42,328	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	5,745	0	0	0	0	0	0	0	0	5,745	15
16	TOTAL Health Care and Programs	(207)	0	43,457	6,024	(1,201)	0	0	0	0	0	0	48,073	16
	C. General Administration													
17	Administrative	0	0	108,619	0	0	0	0	0	0	0	0	108,619	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,290)	0	(476,788)	0	0	0	0	0	0	0	0	(478,078)	19
20	Fees, Subscriptions & Promotions	(12,316)	0	(84,777)	0	0	0	0	0	0	0	0	(97,093)	20
21	Clerical & General Office Expenses	(13,148)	0	166,735	0	0	0	0	0	0	0	0	153,587	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(2,249)	0	0	0	0	0	0	(2,249)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	763	0	0	0	0	0	0	0	0	763	24
25	Other Admin. Staff Transportation	0	0	8,348	0	0	0	0	0	0	0	0	8,348	25
26	Insurance-Prop.Liab.Malpractice	0	0	177	0	0	0	0	0	0	0	0	177	26
27	Other (specify):*	(224,334)	0	44,706	0	0	0	0	0	0	0	0	(179,628)	27
28	TOTAL General Administration	(251,088)	0	(232,217)	0	(2,249)	0	0	0	0	0	0	(485,554)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(243,449)	0	(156,761)	(12,444)	(3,450)	0	(28)	1,185	0	0	0	(414,947)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(19,245)	0	2,782	0	0	0	0	0	0	0	0	(16,463) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(53,106)	0	52,072	0	0	0	0	0	0	0	0	(1,034) 32
33	Real Estate Taxes	0	0	2,532	0	0	0	0	0	0	0	0	2,532 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	22,868	0	0	0	0	0	0	0	0	22,868 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(72,351)	0	80,254	0	0	0	0	0	0	0	0	7,903 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	(24,909)	(14,595)	80,493	0	0	0	0	0	40,989 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	(24,909)	(14,595)	80,493	0	0	0	0	0	40,989 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(315,800)	0	(76,507)	(37,353)	(18,045)	80,493	(28)	1,185	0	0	0	(366,055) 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	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$		0.00%	\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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%	\$ 2,171	\$	2,171	15
16	V	24 Travel and Seminar		Alden Management Services, Inc.		763		763	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		8,348		8,348	17
18	V	26 Insurance		Alden Management Services, Inc.		177		177	18
19	V	20 Dues and Subscription	85,584	Alden Management Services, Inc.		807		(84,777)	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,782		2,782	20
21	V	33 Real estate taxes		Alden Management Services, Inc.		2,532		2,532	21
22	V	35 Rent - Equipment & Vehic		Alden Management Services, Inc.		22,868		22,868	22
23	V	32 Interest		Alden Management Services, Inc.		52,072		52,072	23
24	V	1 Dietary		Alden Management Services, Inc.		1,788		1,788	24
25	V	3 Housekeeping		Alden Management Services, Inc.		5,243		5,243	25
26	V	7 Employee Benefit - Gen Services		Alden Management Services, Inc.		5,755		5,755	26
27	V	10 Nurse & Medical Records Salary		Alden Management Services, Inc.		37,712		37,712	27
28	V	15 Employee Benefit - Health Care		Alden Management Services, Inc.		5,745		5,745	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		108,619		108,619	29
30	V	27 Employee Benefit - Admin		Alden Management Services, Inc.		44,706		44,706	30
31	V	19 Professional Fee	513,049	Alden Management Services, Inc.		36,261		(476,788)	31
32	V	21 General and Administrative	30,048	Alden Management Services, Inc.		196,783		166,735	32
33	V	6 Repairs and Maintenance	21,477	Alden Management Services, Inc.		38,519		17,042	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 650,158			\$ 573,651	\$ *	(76,507)	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 Diet Consultant	\$ 26,400	Prism Health Care Sevices, Inc.	0.00%	\$	\$ (26,400)
16	V	1 Diet Salary		Prism Health Care Sevices, Inc.		14,981	14,981
17	V	2 Tube Feeding	44,964	Prism Health Care Sevices, Inc.		21,749	(23,215)
18	V	10 Equipment Rental	6,660	Prism Health Care Sevices, Inc.		9,694	3,034
19	V	39 Ancillary Supplies	70,012	Prism Health Care Sevices, Inc.		22,592	(47,420)
20	V	1 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		3,658	3,658
21	V	2 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		12,508	12,508
22	V	10 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		2,990	2,990
23	V	39 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		22,511	22,511
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		\$ 148,036			\$ 110,683	\$ * (37,353)

* 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	\$ 193,640	Forum Extended Care Services II, Inc.	0.00%	\$ 178,742	\$ (14,898)
16	V	39 IV	9,508	Forum Extended Care Services II, Inc.		8,776	(732)
17	V	39 Wound Care Products	13,530	Forum Extended Care Services II, Inc.		12,489	(1,041)
18	V	10 House Stock	13,312	Forum Extended Care Services II, Inc.		12,288	(1,024)
19	V	10 Pharmacy Consultant	2,304	Forum Extended Care Services II, Inc.		2,127	(177)
20	V	22 Employee Vaccination	2,249	Forum Extended Care Services II, Inc.			(2,249)
21	V	39 Employee Vaccination		Forum Extended Care Services II, Inc.		2,076	2,076
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		\$ 234,543			\$ 216,498	\$ * (18,045)

* 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 Therapy	\$ 514,423	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 594,916	\$ 80,493	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		\$ 514,423			\$ 594,916	\$ *	80,493	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 Repairs and Maintenance	\$ 21,065	Alden Bennett Construction Company, Inc.	0.00%	\$ 21,037	\$ (28)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 21,065			\$ 21,037	\$ * (28)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs and Maintenance	\$ 5,405	Alden Design Group, Inc.	0.00%	\$ 6,590	\$ 1,185	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		\$ 5,405			\$ 6,590	\$ *	1,185	39

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

Facility Name & ID Number

Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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 Professional Center, LP		Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care Services II, Inc.		Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	FECS of Central Illinois, Inc.		Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomingtondale	Alden Management Services, Inc.		Management	5
6			Alden Terrace of McHenry Rehabilitation and E	McHenry	Alden Gardens of Bloomingtondale, Inc.		Supportive Living F	6
7			Wentworth Rehabilitation and Health Care Cen	Chicago	Alden Garden Courts of DesPlaines, LLC		Assisted Living/Alzh	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Waterford, LLC		SNF & Alzheimers I	8
9			Alden - Valley Ridge Rehabilitation and Health	Bloomingtondale	Alden Gardens of Waterford, LLC		Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingtondale	Prism Health Care Services, Inc.		Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health	Orland Park	Community Physical Therapy & Associates, Lt		Therapy Provider	11
12			Princeton Rehabilitation and Health Care Cent	Chicago	Alden Bennett Construction Company, Inc.		General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipment, LLC		Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, Inc.		Design & Engineeri	14
15			Alden Trails, Inc.	Bloomingtondale				15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for Seniors, Inc		Private duty care	16
17			Alden - North Shore Rehabilitation and Health	(Skokie	Family Home Health Services, Inc.		Home health & hosp	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	Alden Courts of Shorewood, Inc.		SNF	29
30			Alden - Long Grove Rehabilitation and Health	C Long Grove				30

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr # 0040709 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	Chairman-Board of D	Chairman	100.00	180,555	0.96	2.40	Salary	\$ 4,445	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	97,597	0.96	2.40	Salary	2,403	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	97,597	0.96	2.40	Salary	2,403	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	112,136	0.96	2.40	Salary	2,761	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	61,445	0.96	2.40	Salary	1,513	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	144,740	0.96	2.40	Salary	3,564	6-7	6
7	A. Floyd Schlossberg is the Chairman of the Board of Directors, Alden Management Services, Inc.										
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.										
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.										
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.										
11	E. Audra Elisco is the daughter of Floyd Schlossberg. Audra is a training coordinator for our Quality Assurance Program.										
12	F. Randi Schlossberg-Schullo is the daughter of Floyd Schlossberg. Randi is President of Alden Management Services, Inc.										
13								TOTAL	\$ 17,089		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 Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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	1,320,269	35	\$ 90,340	\$ 31,725	\$ 2,171	1	
2	24	Trav & Seminar	Patient Days	1,320,269	35	31,744	31,725	763	2	
3	25	Other Admin Travel	Patient Days	1,320,269	35	347,420	31,725	8,348	3	
4	26	Insurance	Patient Days	1,320,269	35	7,373	31,725	177	4	
5	20	Dues & Subscriptions	Patient Days	1,320,269	35	33,588	31,725	807	5	
6	30	Depreciation	No of Providers/usage	35	35	119,326	1	2,782	6	
7	33	Real Estate Tax	Patient Days/usage	1,320,269	35	129,699	31,725	2,532	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,320,269	35	951,681	31,725	22,868	8	
9	32	Interest	Patient Days/usage	1,320,269	35	2,187,612	31,725	52,072	9	
10	1	Dietary Salary	Patient Days	1,320,269	35	74,426	74,426	31,725	1,788	10
11	3	Housekeeping Salary	Patient Days	1,320,269	35	218,203	218,203	31,725	5,243	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,320,269	35	239,508	31,725	5,755	12	
13	10	Nurs & Med Records Salary	Patient Days	1,320,269	35	1,647,662	1,647,662	31,725	37,712	13
14	15	Employee Benefits -Health Care	Patient Days	1,320,269	35	239,077	31,725	5,745	14	
15	17	Administrative Salary	Patient Days/usage	1,320,269	35	4,750,005	4,750,005	31,725	108,619	15
16	27	Employee Benefits - Admin	Patient Days	1,320,269	35	1,860,472	31,725	44,706	16	
17	19	Professional fees	Patient Days	1,320,269	35	1,119,817	920,527	31,725	36,261	17
18	21	Gen'I & Admin	Patient Days	1,320,269	35	8,189,318	7,151,399	31,725	196,783	18
19	6	Repair & Maint.	Patient Days	1,320,269	35	1,940,174	1,358,004	31,725	38,519	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 24,177,445	\$ 16,120,226	\$ 573,651	25	

Facility Name & ID Number

Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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		7	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							\$	\$			\$	1						
2												2						
3												3						
4	Insurance Interest (GL7053/7030)	x		Medical Malpractice								1,669	4					
5													5					
Working Capital																		
6	Related party-AMS											52,072	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$			\$	53,741	9					
B. Non-Facility Related*																		
10	Interest Income (GL 4975)											(7,235)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(7,235)	14					
15	TOTALS (line 9+line14)						\$	\$			\$	46,506	15					

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

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

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

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 2016 report.			\$	116,600	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.)			\$	123,714	2																				
3.	Under or (over) accrual (line 2 minus line 1).			\$	7,114	3																				
4.	Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	127,400	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.)			\$	(180)	6																				
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	134,334	7																				
Real Estate Tax History:		Plus: Related Party Taxes - See Pg RE_Tax		\$	2,532																					
		Total Real Estate Tax Expense, Sch V, Line 33		\$	136,866																					
Real Estate Tax Bill for Calendar Year:		2012	114,306	8	FOR BHF USE ONLY <table border="1" style="width: 100%;"> <tr> <td style="width: 5%;">13</td> <td style="width: 75%;">FROM R. E. TAX STATEMENT FOR 2016</td> <td style="width: 10%;">\$</td> <td style="width: 10%;"></td> <td style="width: 5%; text-align: center;">13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td></td> <td style="text-align: center;">14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td></td> <td style="text-align: center;">15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td></td> <td style="text-align: center;">16</td> </tr> </table>		13	FROM R. E. TAX STATEMENT FOR 2016	\$		13	14	PLUS APPEAL COST FROM LINE 5	\$		14	15	LESS REFUND FROM LINE 6	\$		15	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
13	FROM R. E. TAX STATEMENT FOR 2016	\$		13																						
14	PLUS APPEAL COST FROM LINE 5	\$		14																						
15	LESS REFUND FROM LINE 6	\$		15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16																						
		2013	115,853	9																						
		2014	118,186	10																						
		2015	113,187	11																						
		2016	123,714	12																						
The current year accrual is based on an estimated 3% increase of the prior year tax.																										

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Lincoln Rehab & HC Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>See attached (Supplement)</u>	<u>Related party-Alden Management</u>	\$ <u>105,372.00</u>	\$ <u>2,532.00</u>
2. _____	_____	\$ _____	\$ _____
3. <u>14-28-108-023-000</u>	<u>Nursing Home Facility</u>	\$ <u>123,714.00</u>	\$ <u>123,714.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>229,086.00</u></u>	\$ <u><u>126,246.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	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											4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sprinkler heads	1995		1,832	73	25	73		1,627	9
10		Roof repairs	1995		2,000		10			2,000	10
11		Installed Electric AMPS	1996		1,870		5			1,870	11
12		Signs	1996		1,800		10			1,800	12
13		Water Heater	1997		6,180		5			6,180	13
14		Replace Pipes	1997		5,949		5			5,949	14
15		Exhaust Fans	1997		8,403		5			8,403	15
16		Washing machine motor	1998		1,576		8			1,576	16
17		ABC (General construction) Major repairs/improvement	1999		5,713		10			5,713	17
18		ABC (General construction) Major repairs/improvement	1999		2,326		10			2,326	18
19		ABC (General construction) Major repairs/improvement	1999		2,092		10			2,092	19
20		ABC (General construction) Major repairs/improvement	1999		1,870		10			1,870	20
21		ABC (General construction) Major repairs/improvement	1999		12,658		10			12,658	21
22		ABC (General construction) Major repairs/improvement	1999		2,250		10			2,250	22
23		ABC (General construction) Major repairs/improvement	1999		10,225		10			10,225	23
24		Climate Services (exhaust fan)	1999		2,280		5			2,280	24
25		Oxygen exhaust system	2000		8,555		8			8,555	25
26		Elevator door repair	2000		1,518		5			1,518	26
27		Lawn Sprinkler	2000		15,500	620	25	620		10,747	27
28		ABC (General construction) Major repairs/improvement	2000		6,937		5			6,937	28
29		ABC (General construction) New hot water system	2000		49,596	2,480	20	2,480		44,226	29
30		ABC (General construction) Replace showers	2000		23,903		10			23,903	30
31		Replace Fire Pump	2001		3,230	162	20	162		2,752	31
32		14 Kilowatt water heater booster	2001		2,783		10			2,783	32
33		ABC (General construction) Major repairs/improvement	2001		3,402		5			3,402	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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	
37	Capps Plumbing (pipe & wall repair)	2002	1,985		5			1,985	37
38	ABC (misc construction work)	2002	3,442		5			3,442	38
39	ABC (repair ejector pump)	2002	7,893		5			7,893	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		2,528	40
41	TNS (DSL Cable)	2004	1,358		5			1,358	41
42	ABC (1st Floors Stairs)	2004	1,699		10			1,699	42
43	Oak Fire security System, new base dual zone card	2005	1,350		5			1,350	43
44	Washtown (repair Washer motor)	2005	1,563		5			1,563	44
45	ABC (repair Mop basin)	2005	1,613		5			1,613	45
46	ABC - seal holes and replace fill materials 3rd floor	2006	5,793		10			5,793	46
47	TopNotch - booster heater	2006	3,217		10			3,217	47
48	ABC - wall covering	2007	10,494	353	10	353		10,494	48
49	ABC - HM door and frame	2008	3,270	327	10	327		3,161	49
50	Central States - springkler system	2008	3,700		5			3,700	50
51	ABC - patio door	2008	2,501	250	10	250		2,313	51
52	ABC - repair electrical room and patio doors	2008	2,915	292	10	292		2,652	52
53	JD Roofing - asphalt roof patched	2009	3,600	360	10	360		3,000	53
54	Oak Fire - wirings for sprinkler system	2009	5,070	507	10	507		4,352	54
55	ABC - roof replaced	2010	3,886	389	10	389		2,853	55
56	ABC - elevator	2010	66,555	3,328	20	3,328		23,573	56
57	Rockford - railings repaired	2010	4,440	444	10	444		3,330	57
58									58
59	Elevator cylinder replacement - South elevator - ABC	2011	14,809	740	20	740		4,625	59
60	Pipes boiler room repair - ABC	2011	7,669	383	20	383		2,330	60
61	Pump, main circuit boiler, Grease trap - ABC	2011	5,097		5			5,097	61
62	Pump, main controller - ABC	2011	3,828	383	10	383		2,362	62
63	Kone - elevator, motor soft starter	2012	13,882	694	20	694		3,991	63
64	ABC - fence and guard rails	2012	5,080	339	15	339		1,949	64
65	ABC - railings	2012	5,491	366	15	366		2,074	65
66	ABC - Boiler Pacific	2012	7,225	361	20	361		2,016	66
67	ABC - fire alarm system	2012	18,456	1,846	10	1,846		10,307	67
68	ABC - boiler leak	2012	6,605	660	10	660		3,630	68
69	GT Mech - fire dampers	2012	4,632	463	10	463		2,431	69
70	TOTAL (lines 4 thru 69)		\$ 416,841	\$ 15,984		\$ 15,984	\$	\$ 306,323	70

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

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 12A, Carried Forward		\$ 416,841	\$ 15,984		\$ 15,984	\$	\$ 306,323	1
2	ABC - laundry and kitchen shaft carpentry and dry wall	2013	53,581	3,572	15	3,572		16,074	2
3	ABC - vent shaft, laundry dampers	2013	21,033	1,402	15	1,402		6,192	3
4	ABC - fire exhaust	2013	4,050	405	10	405		1,755	4
5									5
6	ABC - carpentry, dry wall	2014	6,452	430	15	430		1,648	6
7	Topnotch - freezer/major rebuild	2014	3,654	731	5	731		2,741	7
8									8
9	pump sewage repair - ABC	2015	2,695	539	5	539		1,572	9
10									10
11	Boiler repair - GT Mech	2016	4,775	955	5	955		1,671	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	TOTAL (lines 1 thru 33)		\$ 513,081	\$ 24,018		\$ 24,018	\$	\$ 337,976	34

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

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 12B, Carried Forward	\$ 513,081	\$ 24,018		\$ 24,018	\$	\$ 337,976		1
2	adjust for ABC Related Party Profit	2008 (50)	(8)		(8)		(50)		2
3	adjust for ABC Related Party Profit	2009 (161)	(6)		(6)		(48)		3
4	adjust for ABC Related Party Profit	2010 (862)	(5)		(5)		(40)		4
5	adjust for ABC Related Party Profit	2011 293	2		2		13		5
6	adjust for ABC Related Party Profit	2012 2,646	262		262		1,441		6
7	adjust for ABC Related Party Profit	2013 1,059	68		68		306		7
8	adjust for ABC Related Party Profit	2014 12	2		2		7		8
9	adjust for ABC Related Party Profit	2015 5	2		2		5		9
10	adjust for ABC Related Party Profit	2016 53	4		4		6		10
11	adjust for ABC Related Party Profit	2017 40	1		1		1		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	TOTAL (lines 1 thru 33)	\$ 516,116	\$ 24,340		\$ 24,340	\$	\$ 339,617		34

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

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

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		\$ 516,116	\$ 24,340		\$ 24,340	\$	\$ 339,617	1
2	Forum Prof Ctr: Remodeling	1979	1,519		20			15,192	2
3	Forum Prof Ctr: Build Improv - multiple	1980	29,587		15			29,587	3
4	Forum Prof Ctr: Tennant Improv	1986	934		13			934	4
5	Forum Prof Ctr: AMS remodel	1990	6,346		10			6,346	5
6	Forum Prof Ctr: Roof	1994	3,347		16			3,347	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,180		16			1,180	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,864		10			1,864	8
9	Forum Prof Ctr: Remodel/electrical	2001	726		7			726	9
10	Forum Prof Ctr: bathroom remodel	2002	642		5			642	10
11	Forum Prof Ctr: remodel suites/etc.	2003	825		9			825	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,541		7			2,541	12
13	Forum Prof Ctr: Suite renovation	2005	2,451		10			2,451	13
14	Forum Prof Ctr: Superior installations, etc.	2006	123		4			123	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	493		7			493	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	423		7			423	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	862	92	10	92		700	17
18	Forum Prof Ctr: Building Renovations	2010	1,468		5			1,468	18
19	Forum Prof Ctr: Building Renovations	2011	4,608	365	10	365		2,978	19
20	Forum Prof Ctr: Building Renovations	2012	280	38	15	38		228	20
21	Forum Prof Ctr: Building Renovations	2013	420	60	7	60		230	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	427	43	10	43		140	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	347	99	10	99		231	23
24	Forum Prof Ctr: Suite 116 walls/lighting/floor, renov.	2017	979	73	13	73		73	24
25	Forum Prof Ctr: Paving and sidewalks	2015	3,318	253	7	253		3,018	25
26	Alden Mgt Servs: Remodel suites	1993	6,764		7			6,764	26
27	Alden Mgt Servs: Remodel suites	2002	282		13			282	27
28	Alden Mgt Servs: Remodel suites	2003	6,115		8			6,115	28
29	Alden Mgt Servs: Motor Controller PC Board	2014	83	17	5	17		60	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 595,070	\$ 25,380		\$ 25,380	\$	\$ 428,578	34

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

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 277,211	\$ 28,264	\$ 28,264	\$		\$ 134,709	71
72	Current Year Purchases	93,660	1,986	1,986			1,986	72
73	Fully Depreciated Assets	363,089	104	104			363,089	73
74								74
75	TOTALS	\$ 733,960	\$ 30,354	\$ 30,354	\$		\$ 499,784	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	3,911				3	3,911	77
78										78
79										79
80	TOTALS			\$ 3,911	\$	\$	\$		\$ 3,911	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)	\$ 1,332,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,734	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,734	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)	\$ 932,273	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 Lincoln Rehab & HC Ctr

0040709

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL Enterprises

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:		<u>96</u>		\$ <u>400,480</u>	<u>6</u>	<u>6</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$ 400,480			7

10. Effective dates of current rental agreement:

Beginning 12/26/2012

Ending 02/28/2023

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2018</u>	\$ <u>400,480</u>
13.	<u>12/31/2019</u>	\$ <u>400,480</u>
14.	<u>12/31/2020</u>	\$ <u>400,480</u>

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: Payment of \$448,817 exercisable *

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: \$ 14,558 Description: copy machine GL 6861 and equipment lease GL 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party-PG 6A</u>	<u>various</u>	\$ <u>850.92</u>	\$ <u>10,211</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 850.92	\$ 10,211	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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nursing on site.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 161,520	\$		\$ 161,520	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			111,008			111,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			218,466			218,466	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				180,818		180,818	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				80,493	84,856		165,349	12
13	Other (specify):	See Pg 16A								13
14	TOTAL			\$		\$ 571,487	\$ 265,674		\$ 837,161	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.

Page 16
 Col 5: PT,OT, & ST
 Col 6: Supplies

XIV. Special Services (Direct Cost)

Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.		
1.	OT	39-3	To Col 5	\$161,520.00	
2.	ST	39-3	To Col 5	111,008.00	
3.					
4.	PT	39-3	To Col 5	218,466.00	
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			193,640.00	
	Manual Input from Related Party- Forum Drugs & Vaccinations			(12,822.00)	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	180,818.00	
10.					
11.					
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00	
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00	
	Total Exceptional Care (Line 12, Col 8)			0.00	
13.	Other:	See Pg 16A			
13.	Col 5: Manual Input: Related Party - CPT		To Col 5	80,493.00	From Page 6D
	Other			105,204.00	
	Manual Input: Related Party - Prism			(24,909.00)	From Page 6B
	Manual Input: Related Party FECII - I.V.			(732.00)	From Page 6C
	Manual Input: Related Party FECII - Wound Care Products			(1,041.00)	From Page 6C
	Oxygen, from reclass worksheet (Pg 4A)			6,334.00	
13.	Col 6: Supplies Total		To Col 6	84,856.00	
13.	Total Line 13, Column 8			165,349.00	
14.	Total			837,161.00	

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>157,622</u>)	1,348,719		3
4	Supply Inventory (priced at)	2,443		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,593		6
7	Other Prepaid Expenses	14,119		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>	28,792		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,397,666	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	631,196		15
16	Equipment, at Historical Cost	759,826		16
17	Accumulated Depreciation (book methods)	(959,253)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	82,845		21
22	Other Long-Term Assets (spe <u>Purchase Option</u>	288,000		22
23	Other(specify): <u>Due from Affiliate,</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 802,614	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,200,280	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 336,176	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	139,359		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	329,661		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,489		31
32	Accrued Real Estate Taxes(Sch.IX-B)	127,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Exp/Ins,due to IDPA,Sales Tax</u>	64,496		36
37	<u>Due to Affiliates</u>	693,451		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,706,032	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	4,165,093		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,165,093	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,871,125	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,670,845)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,200,280	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,251,956)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,251,956)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(418,889)	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)	\$ (418,889)	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)	\$ (3,670,845)	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	\$ 6,347,504	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,347,504	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	235,832	6
7	Oxygen	22,207	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 258,039	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	68	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,835	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,903	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,235	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19A	1,051	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,051	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,620,732	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,008,814	31
32	Health Care	2,387,724	32
33	General Administration	1,958,950	33
B. Capital Expense			
34	Ownership	665,104	34
C. Ancillary Expense			
35	Special Cost Centers	789,838	35
36	Provider Participation Fee	229,191	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,039,621	40
41	Income before Income Taxes (line 30 minus line 40)**	(418,889)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (418,889)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,762,422	44
45	Private Pay - Net Inpatient Revenue	662,383	45
46	Medicare - Net Inpatient Revenue	1,142,828	46
47	Other-(specify) <u>Hospice/Insurance</u>	425,238	47
48	Other-(specify) <u>Veterans</u>	354,633	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,347,504	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 Lincoln Rehab & HC Ctr

0040709

Report Period Beginning 01/01/2017 Ending:

12/31/2017

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc. Income GL#4977 (discribe) (is offset against Sch.# V)	
Record Copies-Backed out with Ln ref 21-Pg 5A	207
Jury Duty-Backed out with Ln ref 22-Pg 5A	69
Food Rebate	769
Vendor Discount	6
Line 28 Total:	<u><u>1,051</u></u>

Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	2,024	2,080	\$ 102,244	\$ 49.16	1
2	Assistant Director of Nursing	1,075	1,203	48,880	40.63	2
3	Registered Nurses	15,666	16,632	532,148	32.00	3
4	Licensed Practical Nurses	16,934	17,803	497,978	27.97	4
5	CNAs & Orderlies	53,874	56,903	801,515	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,458	1,576	31,004	19.67	9
10	Activity Assistants	3,539	3,844	44,248	11.51	10
11	Social Service Workers	1,816	2,064	50,496	24.47	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,080	53,410	25.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,451	13,982	174,676	12.49	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,080	48,053	23.10	17
18	Housekeepers	12,778	13,974	167,201	11.97	18
19	Laundry	1,963	2,095	23,763	11.34	19
20	Administrator	1,896	2,080	103,655	49.83	20
21	Assistant Administrator					21
22	Other Administrative	1,752	2,080	63,512	30.53	22
23	Office Manager					23
24	Clerical	6,684	7,067	98,078	13.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,904	2,080	86,456	41.57	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,678	149,623	\$ 2,927,317 *	\$ 19.56	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	2200/mo	\$ 26,400	1-3	35
36	Medical Director	750/mo	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	192/mo	2,304	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	220/mo	2,640	11-3	44
45	Social Service Consultant	280/mo	840	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,184		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8 hrs	1,573	10-3	52
53	TOTAL (lines 50 - 52)		\$ 1,573		53

Alden Lincoln Rehab & HC Ctr
 Legal Fee Support
 2017

Legal Fees Reported on Pg 21, Section C:	51,716.00
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22	(5,234.00)
Non-allowable legal fees, if any, deducted on - Pg 6A (AMS Allocated Legal Fees) + Add Back voided invoice of prior year, if any	(45,192.00)
Allowable Legal Fees	<u>1,290.00</u>

In Detail:

Vendor Name - 696600-100-000 Legal Fees - Collections	Invoice Date	Amount
Leonard Smith ABCACC	04/30/17	131.00
Recorder of Deeds (RECCOO)	06/30/17	40.00
Clerk of the Circuit County	04/17 and 11/17	812.00
Ariana Fisch/SEOWC	01/17 and 05/17	27.00
Markley Investigations	06/30/17	100.00
Sheriff of Cook County	04/30/17	180.00
TOTAL ALLOWABLE LEGAL FEES		<u>1,290.00</u>

Vendor Name - 680600-100-000 - Legal Fees Non-Collections	Invoice Date	Amount
Von Briesen Law Groups	06/17 to 11/17	849.00
Midcap	01/17 to 12/17	1,596.00
Chicago Kent Law	06/17 to 11/17	2,789.00

TOTAL Collection-NOT ALLOWABLE LEGAL FEES	<u>5,234.00</u>
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Vendor Name - 680600-100-003 - AMS Allocated Legal Fees	Invoice Date	Amount
AMS Corporate Allocation - Legal Costs	01/17 to 12/17	45,192.00

TOTAL Allocated Legal Fees	<u>45,192.00</u>
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Total Legal Cost	<u>51,716.00</u>
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Facility Name & ID Number Alden Lincoln Rehab & HC Ctr

0040709

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? CNA: Yes; RN/LPN: N (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
- (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 \$9,216
- (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? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,726 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. \$ 229,191
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.
- (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. \$ 31,439 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