



Facility Name & ID Number Alden Springs

# 0047191 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		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	5,604			5,604	13
14	TOTALS	5,604			5,604	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 95.96%

**D. How many bed reserve days during this year were paid by the Department?**  
116 (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 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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Alden Springs # 0047191 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
	<b>A. General Services</b>										
1	Dietary	69,275	2,986	3,840	76,101	935	77,036	(499)	76,537		1
2	Food Purchase		45,064		45,064	(3,327)	41,737	(2,556)	39,181		2
3	Housekeeping	9,472	5,090		14,562		14,562	926	15,488		3
4	Laundry		4,820		4,820		4,820		4,820		4
5	Heat and Other Utilities			23,518	23,518		23,518	62	23,580		5
6	Maintenance		410	53,933	54,343		54,343	190	54,533		6
7	Other (specify):* <b>related party/Security</b>			300	300		300	1,038	1,338		7
8	<b>TOTAL General Services</b>	78,747	58,370	81,591	218,707	(2,392)	216,315	(839)	215,476		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	598,873	25,915	850	625,637	761	626,398	7,168	633,566		10
10a	Therapy			5,551	5,551		5,551	1,508	7,059		10a
11	Activities	20,902	45	808	21,755		21,755		21,755		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>related party</b>							1,004	1,004		15
16	<b>TOTAL Health Care and Programs</b>	619,775	25,960	10,809	656,543	761	657,304	9,680	666,984		16
	<b>C. General Administration</b>										
17	Administrative	17,694			17,694		17,694	19,838	37,532		17
18	Directors Fees										18
19	Professional Services			92,561	92,561		92,561	(70,211)	22,350		19
20	Dues, Fees, Subscriptions & Promotions			4,374	4,374		4,374	(747)	3,627		20
21	Clerical & General Office Expenses	23,598	1,897	24,933	50,428		50,428	25,419	75,847		21
22	Employee Benefits & Payroll Taxes			93,140	93,140	1,631	94,771	(168)	94,603		22
23	Inservice Training & Education										23
24	Travel and Seminar			19	19		19	135	154		24
25	Other Admin. Staff Transportation			379	379		379	1,480	1,859		25
26	Insurance-Prop.Liab.Malpractice			21,658	21,658		21,658	1,629	23,287		26
27	Other (specify):* <b>related party</b>			240	240		240	7,670	7,910		27
28	<b>TOTAL General Administration</b>	41,292	1,897	237,303	280,492	1,631	282,123	(14,955)	267,168		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	739,814	86,227	329,703	1,155,743		1,155,743	(6,114)	1,149,629		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 &amp; ID Number

Alden Springs

#0047191

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			17,173	17,173		17,173	46,067	63,240			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,948	7,948		7,948	77,776	85,724			32
33	Real Estate Taxes			34,800	34,800	(34,800)		35,247	35,247			33
34	Rent-Facility & Grounds			114,795	114,795	34,800	149,596	(149,596)	(0)			34
35	Rent-Equipment & Vehicles			953	953		953	4,039	4,992			35
36	Other (specify):* MIP											36
37	<b>TOTAL Ownership</b>			175,670	175,670		175,670	13,533	189,203			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,424		18,424		18,424	(6,280)	12,144			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,162	72,162		72,162		72,162			42
43	Other (specify):* day training			278,581	278,581		278,581		278,581			43
44	<b>TOTAL Special Cost Centers</b>		18,424	350,743	369,167		369,167	(6,280)	362,887			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	739,814	104,650	856,116	1,700,580		1,700,580	1,139	1,701,719			45

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

0047191 Alden Springs  
 Period Beginning: 01/01/2017  
 Period Ending: 12/31/2017

IDPH License No. 0

Page 4A

Reclassifications - Pages 3 & 4

From Line	To Line	Amount	Description
2		(3,327)	Employee Meals
	22	3,327	Employee Meals
22		(1,696)	Uniform Reclass
	1	935	Uniform Reclass
	3		Uniform Reclass
	4		Uniform Reclass
	6		Uniform Reclass
	10	761	Uniform Reclass
	11		Uniform Reclass
	21		Uniform Reclass
33		(34,800)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	34,800	Rent - Real Estate Tax on associated landowner (Pg 6)
Net (Should be zero)		-	

Facility Name & ID Number Alden Springs

# 0047191

Report Period Beginning:

01/01/2017

Ending:

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**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	(3,168)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,823)	21		17
18	Fines and Penalties	(62)	32		18
19	Entertainment	(66)	20		19
20	Contributions	(450)	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	(240)	27		24
25	Fund Raising, Advertising and Promotional	(681)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (7,490)		\$	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)	2,343	Pg 6s	34
35	Other- Attach Schedule	6,286	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 8,629		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,139		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Alden Springs

ID# 0047191

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Late Fees on Utilities	\$ (321)	5	1
2	Employee Flu Shots	(38)	21	2
3	Intercompany Interest Not allowed (GL#7031)	(7,607)	32	3
4	Elim. Land Owner bank charges	0	19	4
5	Gain/Loss on FMV of Swap	17,569	32	5
6	Marketing Manager & Aides	0	21	6
7	Elim Deprec Exp on Pg 13 items under \$2500	(3,124)	30	7
8	Expense Pg 13 items < \$2,500 Curr Yr	818	6	8
9	Elim Deprec on Pg 12 < \$2,500 items	(453)	30	9
10	Expense Pg 12 items < \$2,500 Curr Yr	0	6	10
11	Adj YTD Deprec Exp to Detail	(558)	30	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	<b>Total</b>	6,286		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Springs

# 0047191

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	316	(815)	0	0	0	0	0	0	0	(499)	1
2	Food Purchase	0	0	0	(2,556)	0	0	0	0	0	0	0	(2,556)	2
3	Housekeeping	0	0	926	0	0	0	0	0	0	0	0	926	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(321)	0	383	0	0	0	0	0	0	0	0	62	5
6	Maintenance	(2,350)	0	2,399	0	0	0	(10)	151	0	0	0	190	6
7	Other (specify):*	0	0	1,038	0	0	0	0	0	0	0	0	1,038	7
8	<b>TOTAL General Services</b>	<b>(2,671)</b>	<b>0</b>	<b>5,062</b>	<b>(3,371)</b>	<b>0</b>	<b>0</b>	<b>(10)</b>	<b>151</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(839)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	6,662	771	(265)	0	0	0	0	0	0	7,168	10
10a	Therapy	0	0	0	0	0	1,508	0	0	0	0	0	1,508	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	1,004	0	0	0	0	0	0	0	0	1,004	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>7,666</b>	<b>771</b>	<b>(265)</b>	<b>1,508</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9,680</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	19,838	0	0	0	0	0	0	0	0	19,838	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(70,211)	0	0	0	0	0	0	0	0	(70,211)	19
20	Fees, Subscriptions & Promotions	(1,197)	307	143	0	0	0	0	0	0	0	0	(747)	20
21	Clerical & General Office Expenses	(2,861)	0	28,280	0	0	0	0	0	0	0	0	25,419	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(168)	0	0	0	0	0	0	(168)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	135	0	0	0	0	0	0	0	0	135	24
25	Other Admin. Staff Transportation	0	0	1,480	0	0	0	0	0	0	0	0	1,480	25
26	Insurance-Prop.Liab.Malpractice	0	1,598	31	0	0	0	0	0	0	0	0	1,629	26
27	Other (specify):*	(240)	0	7,910	0	0	0	0	0	0	0	0	7,670	27
28	<b>TOTAL General Administration</b>	<b>(4,298)</b>	<b>1,905</b>	<b>(12,394)</b>	<b>0</b>	<b>(168)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,955)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(6,969)</b>	<b>1,905</b>	<b>334</b>	<b>(2,600)</b>	<b>(433)</b>	<b>1,508</b>	<b>(10)</b>	<b>151</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,114)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Springs

# 0047191

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	(4,135)	47,420	2,782	0	0	0	0	0	0	0	0	46,067	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	9,900	59,133	8,743	0	0	0	0	0	0	0	0	77,776	32
33	Real Estate Taxes	0	34,800	447	0	0	0	0	0	0	0	0	35,247	33
34	Rent-Facility & Grounds	0	(149,596)	0	0	0	0	0	0	0	0	0	(149,596)	34
35	Rent-Equipment & Vehicles	0	0	4,039	0	0	0	0	0	0	0	0	4,039	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>5,765</b>	<b>(8,243)</b>	<b>16,011</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,533</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(6,241)	(39)	0	0	0	0	0	0	(6,280)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,241)</b>	<b>(39)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,280)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,204)</b>	<b>(6,338)</b>	<b>16,345</b>	<b>(8,841)</b>	<b>(472)</b>	<b>1,508</b>	<b>(10)</b>	<b>151</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,139</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 149,596	Alden Trails II, LLC	0.00%	\$	\$ (149,596)	1
2	V	6 Repairs & Maintenance		Alden Trails II, LLC				2
3	V	19 Bank Charges		Alden Trails II, LLC				3
4	V	33 Real Estate Tax Expense		Alden Trails II, LLC		34,800	34,800	4
5	V	26 General Insurance Expense		Alden Trails II, LLC		1,598	1,598	5
6	V	32 Interest - Mortgage		Alden Trails II, LLC		75,234	75,234	6
7	V	30 Depreciation		Alden Trails II, LLC		47,420	47,420	7
8	V	21 Miscellaneous Costs		Alden Trails II, LLC				8
9	V	20 Corporate Annual Report Fee		Alden Trails II, LLC		307	307	9
10	V	19 Professional Fees		Alden Trails II, LLC				10
11	V	32 Amortization Expense		Alden Trails II, LLC		1,468	1,468	11
12	V	32 Gain/Loss on FMV of SWAP	17,569	Alden Trails II, LLC			(17,569)	12
13	V							13
14	Total		\$ 167,165			\$ 160,827	\$ * (6,338)	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%	\$ 383	\$	383	15
16	V	24 Trav & Seminar		Alden Management Services, Inc.		135		135	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,480		1,480	17
18	V	26 Insurance		Alden Management Services, Inc.		31		31	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		143		143	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,782		2,782	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		447		447	21
22	V	35 Rent-Equip & Vehicles		Alden Management Services, Inc.		4,039		4,039	22
23	V	32 Interest		Alden Management Services, Inc.		8,743		8,743	23
24	V	1 Dietary		Alden Management Services, Inc.		316		316	24
25	V	3 Housekeeping		Alden Management Services, Inc.		926		926	25
26	V	7 Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		1,038		1,038	26
27	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		6,662		6,662	27
28	V	15 Employee Benefits-Health Care		Alden Management Services, Inc.		1,004		1,004	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		19,838		19,838	29
30	V	27 Employee Benefits-Admin		Alden Management Services, Inc.		7,910		7,910	30
31	V	19 Professional Fees	87,771	Alden Management Services, Inc.		17,560		(70,211)	31
32	V	21 Gen'l & Admin	6,480	Alden Management Services, Inc.		34,760		28,280	32
33	V	6 Repair & Maint	3,464	Alden Management Services, Inc.		5,863		2,399	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 97,715			\$ 114,060	\$ *	16,345	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%	\$ 2,043	\$ (1,557)
16	V	1 Dietary Salary		Prism Health Care Sevices, Inc.			
17	V	2 Tube feeding	10,176	Prism Health Care Sevices, Inc.		5,082	(5,094)
18	V	10 Equip. Rental	360	Prism Health Care Sevices, Inc.		524	164
19	V	39 Ancillary supplies	15,896	Prism Health Care Sevices, Inc.		5,088	(10,808)
20	V	1 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		742	742
21	V	2 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		2,538	2,538
22	V	10 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		607	607
23	V	39 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		4,567	4,567
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		\$ 30,032			\$ 21,191	\$ * (8,841)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Drugs	\$ 1,449	Forum Extended Care Services II, Inc.	0.00%	\$ 1,338	\$ (111)
16	V	39 I.V.		Forum Extended Care Services II, Inc.			
17	V	39 Wound Care Products	1,078	Forum Extended Care Services II, Inc.		995	(83)
18	V	10 House Stock	3,052	Forum Extended Care Services II, Inc.		2,817	(235)
19	V	10 Pharm Consult	384	Forum Extended Care Services II, Inc.		354	(30)
20	V	22 Employee Vaccinations	168	Forum Extended Care Services II, Inc.			(168)
21	V	39 Employee Vaccinations		Forum Extended Care Services II, Inc.		155	155
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		\$ 6,131			\$ 5,659	\$ * (472)

\* 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	\$ 5,551	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 7,059	\$ 1,508	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$ 5,551			\$ 7,059	\$ *	1,508	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	\$ 7,338	Alden Bennett Construction Company, Inc.	0.00%	\$ 7,328	\$ (10)
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	<b>Total</b>		\$ 7,338			\$ 7,328	\$ * (10)

\* 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	\$ 688	Alden Design Group, Inc.	0.00%	\$ 839	\$ 151	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$ 688			\$ 839	\$ *	151	39

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

Facility Name &amp; ID Number

Alden Springs

# 0047191

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 &amp; ID Number

Alden Springs

# 0047191

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	184,215	0.168	0.42	Salary	\$ 785	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,576	0.168	0.42	Salary	424	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,576	0.168	0.42	Salary	424	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	114,409	0.168	0.42	Salary	488	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	62,691	0.168	0.42	Salary	267	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	184,215	0.126	0.42	Salary	785	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	\$ 3,173		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:

01/01/2017

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	1,320,269	35	\$ 90,340	\$ 5,604	\$ 383	1	
2	24	Trav & Seminar	Patient Days	1,320,269	35	31,744	5,604	135	2	
3	25	Other Admin Travel	Patient Days	1,320,269	35	348,589	5,604	1,480	3	
4	26	Insurance	Patient Days	1,320,269	35	7,373	5,604	31	4	
5	20	Dues & Subscriptions	Patient Days	1,320,269	35	33,588	5,604	143	5	
6	30	Depreciation	No of Providers/usage	35	35	119,326	5,604	2,782	6	
7	33	Real Estate Tax	Patient Days/usage	1,320,269	35	129,699	5,604	447	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,320,269	35	951,681	5,604	4,039	8	
9	32	Interest	Patient Days/usage	1,320,269	35	2,187,612	5,604	8,743	9	
10	1	Dietary Salary	Patient Days	1,320,269	35	74,426	74,426	5,604	316	10
11	3	Housekeeping Salary	Patient Days	1,320,269	35	218,203	218,203	5,604	926	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,320,269	35	244,557	5,604	1,038	12	
13	10	Nurs & Med Records Salary	Patient Days	1,320,269	35	1,647,662	1,647,662	5,604	6,662	13
14	15	Employee Benefits -Health Care	Patient Days	1,320,269	35	236,654	5,604	1,004	14	
15	17	Administrative Salary	Patient Days/usage	1,320,269	35	4,903,376	4,750,005	5,604	19,838	15
16	27	Employee Benefits - Admin	Patient Days	1,320,269	35	1,863,643	5,604	7,910	16	
17	19	Professional fees	Patient Days	1,320,269	35	1,119,817	920,527	5,604	17,560	17
18	21	Gen'I & Admin	Patient Days	1,320,269	35	8,189,318	7,151,399	5,604	34,760	18
19	6	Repair & Maint.	Patient Days	1,320,269	35	1,823,498	1,358,004	5,604	5,863	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 24,221,106	\$ 16,120,226	\$ 114,060	25	

Facility Name & ID Number

Alden Springs

# 0047191

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	MB Bank (GL 2513/2021/7035)		X	Mortgage	Varies	8/29/12	\$ 1,520,000	\$ 1,341,913	9/05/2022	3.5000	\$ 62,229	1						
2												2						
3	FMV of Derivative		X	Rate Swap interest							13,005	3						
4	Amort of Fin Fees (GL 7105)		x	Refinancing							1,468	4						
5	Insurance Interest (GL7053)		x	Medical Malpractice							278	5						
<b>Working Capital</b>																		
6	Related party-AMS			Working Capital							8,743	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,520,000	\$ 1,341,913			\$ 85,724	9						
<b>B. Non-Facility Related*</b>																		
10	Interest Income (GL 4975)		x									10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,520,000	\$ 1,341,913			\$ 85,724	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.)



**2016 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 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>447.00</u>
2. <u>02-23-300-024</u>	<u>Alden Trails II LLC</u>	\$ <u>34,300.20</u>	\$ <u>34,300.20</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>139,672.20</u></u>	\$ <u><u>34,747.20</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 Springs

# 0047191

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: nursing facility, 22,035, 2006, \$ 398,630, 1. Row 2: 2, 2. Row 3: TOTALS, 22,035, \$ 398,630, 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		2006		1,583,599	39,590	40	39,590		445,387	4
5		2006		69,510	1,738	40	1,738		19,550	5
6		2006		20,156	504	40	504		5,879	6
7										7
8										8
Improvement Type**										
9	Wiring		2006	840	42	20	42		473	9
10										10
11	Drywall Carpentry		2007	18,677	1,245	15	1,245		13,282	11
12	Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127		10			23,127	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Alden Springs

# 0047191

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,715,910	\$ 43,119		\$ 43,119	\$	\$ 507,698	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		17		60	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,794,864	\$ 44,159		\$ 44,159	\$	\$ 596,659	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	\$ 193,785	\$ 18,926	\$ 18,926	\$		\$ 131,516	71
72	Current Year Purchases	55,155	47	47			47	72
73	Fully Depreciated Assets	146,711	108	108			146,711	73
74								74
75	TOTALS	\$ 395,651	\$ 19,081	\$ 19,081	\$		\$ 278,274	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)	\$ 2,593,056	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,240	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)	\$ 878,844	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: 01/01/2017

Ending: 12/31/2017

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning 1/1/2007

Ending 11/1/2026

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

Fiscal Year Ending                      Annual Rent

12. 12/31/2018                      \$ varies

13. 12/31/2019                      \$ varies

14. 12/31/2020                      \$ 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: \$ 1,423      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>150.33</u>	\$ <u>1,804</u>	17
18					18
19	<u>Auto lease - gl 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	<b>TOTAL</b>		\$ <u>150.33</u>	\$ <u>1,804</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? <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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts				1,493		1,493	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					10,651		10,651	13
14	TOTAL			\$		\$	12,144		\$ 12,144	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	\$0.00
2.	ST	39-3	To Col 5	0.00
3.				
4.	PT	39-3	To Col 5	0.00
5.				
6.				
7.				
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities			0.00
				<u>0.00</u>
	<b>Less: OT, ST, &amp; PT costs - reclassified to 10A for DD facilities</b>			0.00
				0.00
	Pharmacy Supplies per GL			1,449.00
	Manual Input from Related Party- Forum Drugs & Vaccinations			44.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	<u>1,493.00</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			16,976.00
	Manual Input: Related Party - Prism			(6,242.00)
	Manual Input: Related Party FECII - I.V.			
	Manual Input: Related Party FECII - Wound Care Products			(83.00)
	Oxygen, from reclass worksheet (Pg 4A)			
13.	Col 6: Supplies Total		To Col 6	<u>10,651.00</u>
13.	Total Line 13, Column 8			<u>10,651.00</u>
14.	Total			<u>12,144.00</u>

Facility Name & ID Number Alden Springs

# 0047191

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 21,945	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100 )	126,053	126,053	3
4	Supply Inventory (priced at )	561	561	4
5	Short-Term Investments			5
6	Prepaid Insurance		1,403	6
7	Other Prepaid Expenses	1,915	1,915	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 128,529	\$ 151,877	10
	<b>B. Long-Term Assets</b>			
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	23,431	23,431	15
16	Equipment, at Historical Cost	130,167	315,316	16
17	Accumulated Depreciation (book methods)	(96,212)	(731,523)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Refinan.Fee</u> )		6,978	22
23	Other(specify): <u>FMV of Derivative</u>		8,605	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 57,386	\$ 1,695,543	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 185,915	\$ 1,847,421	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 104,183	\$ 105,263	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	180	180	28
29	Short-Term Notes Payable		39,977	29
30	Accrued Salaries Payable	90,851	90,851	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,235	3,235	31
32	Accrued Real Estate Taxes(Sch.IX-B)		35,300	32
33	Accrued Interest Payable		6,309	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accr Exp/Ins,d/t PA,SaleTx,etc.</u>	24,803	24,803	36
37	<u>Due to Affiliates</u>	75,000	142,278	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 298,252	\$ 448,196	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,301,937	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to affiliates+Wage allocation</u>	93,114	93,114	43
44	<u>FMV of Derivative</u>			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 93,114	\$ 1,395,051	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 391,366	\$ 1,843,247	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (205,451)	\$ 4,174	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 185,915	\$ 1,847,421	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (34,230)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (34,230)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(211,511)	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) <b>Prior years shared salaries</b>	40,290	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (171,221)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (205,451)	24 *

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

Facility Name &amp; ID Number Alden Springs

# 0047191

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,211,185	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,211,185	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	38	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 38	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Day Training</u>	277,845	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 277,845	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,489,068	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	218,707	31
32	Health Care	656,543	32
33	General Administration	280,492	33
<b>B. Capital Expense</b>			
34	Ownership	175,670	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	297,005	35
36	Provider Participation Fee	72,162	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,700,580	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(211,511)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (211,511)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,211,185	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,211,185	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:

01/01/2017

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		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	4,983	5,199	236,568	45.50	3
4	Licensed Practical Nurses	2,516	2,762	69,309	25.09	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	497	497	10,594	21.32	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,098	4,514	69,275	15.35	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	520	520	9,472	18.22	18
19	Laundry					19
20	Administrator	468	470	17,694	37.65	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)	20,339	22,279	292,996	13.15	30
31	Medical Records					31
32	Other Health C: Facility Manager	944	972	23,598	24.28	32
33	Other(specify) Behavioral Health	321	337	10,308	30.59	33
34	TOTAL (lines 1 - 33)	34,686	37,550	\$ 739,814 *	\$ 19.70	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	320/Monthly	\$ 3,840	1-3	35
36	Medical Director	300/Monthly	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	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	5	248	11-3	44
45	Social Service Consultant	4	560	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	\$ 8,632		49

C. CONTRACT NURSES

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



Legal Fees Reported on Pg 21, Section C: \$ 24,326.97

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) (24,000.00)  
 + Add Back voided invoice of prior year, if any

Allowable Legal Fees \$ 326.97

In Detail:

Vendor Name	Invoice Date	Amount
SIMPRE Simandl Law Group,S.C.	1/20/2017	60.90
MIDCAP Allo.Legal Fees 01/17	1/31/2017	10.70
MIDCAP Allo.Legal Fees 05/17	5/31/2017	214.65
MIDCAP Allo.Legal Fees 08/17	8/31/2017	40.72
<b>TOTAL ALLOWABLE LEGAL FEES</b>		<b><u>326.97</u></b>

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

Vendor Name	Invoice Date	Amount
AMS Legal exp Allocation 2017	1/1/2017	2,000.00
AMS Legal exp Allocation 2017	2/1/2017	2,000.00
AMS Legal exp Allocation 2017	3/1/2017	2,000.00
AMS Legal exp Allocation 2017	4/1/2017	2,000.00
AMS Legal exp Allocation 2017	5/1/2017	2,000.00
AMS Legal exp Allocation 2017	6/1/2017	2,000.00
AMS Legal exp Allocation 2017	7/1/2017	2,000.00
AMS Legal exp Allocation 2017	8/1/2017	2,000.00
AMS Legal exp Allocation 2017	9/1/2017	2,000.00
AMS Legal exp Allocation 2017	10/1/2017	2,000.00
AMS Legal exp Allocation 2017	11/1/2017	2,000.00
AMS Legal exp Allocation 2017	12/1/2017	2,000.00
<b>TOTAL Allocated Legal Fees</b>		<b><u>24,000.00</u></b>

Total Legal Cost 24,326.97

Facility Name &amp; ID Number Alden Springs

# 0047191

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? C.N.A-Yes, RN/LPNs-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 \$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? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,954 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. \$ 72,162  
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. \$ 3,327 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