FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0047191

Facility Name: Alden Springs

Address: 207 E Army Trail Rd (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: (630) 523-5783 **Fax #** (630) 523-5787

HFS ID Number:

Date of Initial License for Current Owners: 9/25/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Randi Schlossberg-Schullo
(Title) President, Alden Management Services, Inc.

Paid Preparer

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

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)		0	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,666			5,666	13
14	TOTALS	5,666			5,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.76%

D. How many bed-hold days during this year were paid by the Department?
136 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 10/13/06

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	61,548	4,436	3,608	69,592	480	70,072	(673)	69,399			1
2	Food Purchase		44,307		44,307	(3,441)	40,866	(1,193)	39,673			2
3	Housekeeping	9,336	5,501		14,837		14,837	794	15,631			3
4	Laundry		4,042		4,042		4,042		4,042			4
5	Heat and Other Utilities			23,945	23,945		23,945	(182)	23,763			5
6	Maintenance			58,769	58,769		58,769	5,330	64,099			6
7	Other (specify):* related party							801	801			7
8	TOTAL General Services	70,884	58,287	86,322	215,493	(2,961)	212,532	4,877	217,409			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	561,887	30,743	603	593,234	390	593,624	7,402	601,026			10
10a	Therapy		7	4,876	4,883		4,883	984	5,867			10a
11	Activities	23,455	55	865	24,375		24,375		24,375			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* related party							795	795			15
16	TOTAL Health Care and Programs	585,342	30,806	9,944	626,092	390	626,482	9,181	635,663			16
	C. General Administration											
17	Administrative	19,419			19,419		19,419	18,150	37,569			17
18	Directors Fees											18
19	Professional Services			91,560	91,560		91,560	(68,132)	23,428			19
20	Dues, Fees, Subscriptions & Promotions			6,120	6,120		6,120	(3,168)	2,952			20
21	Clerical & General Office Expenses	37,490	2,279	23,831	63,599		63,599	13,101	76,700			21
22	Employee Benefits & Payroll Taxes			82,057	82,057	2,571	84,628	(277)	84,351			22
23	Inservice Training & Education											23
24	Travel and Seminar			31	31		31	156	187			24
25	Other Admin. Staff Transportation			371	371		371	1,529	1,900			25
26	Insurance-Prop.Liab.Malpractice			19,861	19,861		19,861	1,746	21,607			26
27	Other (specify):* related party			940	940		940	5,502	6,442			27
28	TOTAL General Administration	56,909	2,279	224,771	283,959	2,571	286,530	(31,393)	255,137			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	713,135	91,371	321,037	1,125,544		1,125,544	(17,335)	1,108,209			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Springs #0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			16,609	16,609		16,609	52,170	68,779			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,917	6,917		6,917	79,871	86,788			32
33	Real Estate Taxes			33,402	33,402	(33,402)	0	34,047	34,047			33
34	Rent-Facility & Grounds			115,539	115,539	33,402	148,941	(148,941)	(0)			34
35	Rent-Equipment & Vehicles			1,576	1,576		1,576	4,551	6,127			35
36	Other (specify):*											36
37	**TOTAL Ownership**			174,044	174,044		174,044	21,698	195,742			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,327		22,327		22,327	(5,956)	16,371			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,098	72,098		72,098		72,098			42
43	Other (specify):* **day training**			261,227	261,227		261,227		261,227			43
44	**TOTAL Special Cost Centers**		22,327	333,325	355,652		355,652	(5,956)	349,696			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	713,135	113,698	828,407	1,655,239		1,655,239	(1,593)	1,653,646			45

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

Reclassifications - Pages 3 & 4

From Line	To Line	Amount	Description
2		(3,441)	Employee Meals
	22	3,441	Employee Meals
22		(870)	Uniform Reclass
	1	480	Uniform Reclass
	3		Uniform Reclass
	4		Uniform Reclass
	6		Uniform Reclass
	10	390	Uniform Reclass
	11		Uniform Reclass
	21		Uniform Reclass
33		(33,402)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	33,402	Rent - Real Estate Tax on associated landowner (Pg 6)
Net (Should be zero)		-	

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,498)	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	(2,401)	21		17
18	Fines and Penalties				18
19	Entertainment	(62)	20		19
20	Contributions	(2,830)	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	(940)	27		24
25	Fund Raising, Advertising and Promotional	(898)	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)**	$ (9,629)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	10,597		34
35	Other- Attach Schedule	(2,561)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 8,036		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,593)		37

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

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

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

Alden Springs

ID# 0047191

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utilities	$ (577)	5	1
2	Employee Flu Shots	(15)	21	2
3	Intercompany Interest Not allowed (GL#7031)	(6,665)	32	3
4	Elim. Land Owner bank charges	0	19	4
5	Gain/Loss on FMV of Swap	18,139	32	5
6	Marketing Manager & Aides	(12,785)	21	6
7	Elim Deprec Exp on Pg 13 items under $2500	(3,659)	30	7
8	Expense Pg 13 items< $2,500 Curr Yr	1,979	6	8
9	Elim Deprec on Pg 12 < $2,500 items	(179)	30	9
10	Expense Pg 12 items< $2,500 Curr Yr	2,057	6	10
11	Adj YTD Deprec Exp to Detail	(856)	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	**Total**	(2,561)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs # 0047191 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	322	(995)	0	0	0	0	0	0	0	(673)	1
2	Food Purchase	0	0	0	(1,193)	0	0	0	0	0	0	0	(1,193)	2
3	Housekeeping	0	0	794	0	0	0	0	0	0	0	0	794	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(577)	0	395	0	0	0	0	0	0	0	0	(182)	5
6	Maintenance	1,538	0	3,778	0	0	0	(35)	49	0	0	0	5,330	6
7	Other (specify):*	0	0	801	0	0	0	0	0	0	0	0	801	7
8	**TOTAL General Services**	961	0	6,090	(2,188)	0	0	(35)	49	0	0	0	4,877	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	6,606	999	(203)	0	0	0	0	0	0	7,402	10
10a	Therapy	0	0	0	0	0	984	0	0	0	0	0	984	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	795	0	0	0	0	0	0	0	0	795	15
16	**TOTAL Health Care and Programs**	0	0	7,401	999	(203)	984	0	0	0	0	0	9,181	16
	C. General Administration													
17	Administrative	0	0	18,150	0	0	0	0	0	0	0	0	18,150	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(68,132)	0	0	0	0	0	0	0	0	(68,132)	19
20	Fees, Subscriptions & Promotions	(3,790)	307	315	0	0	0	0	0	0	0	0	(3,168)	20
21	Clerical & General Office Expenses	(15,201)	0	28,302	0	0	0	0	0	0	0	0	13,101	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(277)	0	0	0	0	0	0	(277)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	156	0	0	0	0	0	0	0	0	156	24
25	Other Admin. Staff Transportation	0	0	1,529	0	0	0	0	0	0	0	0	1,529	25
26	Insurance-Prop.Liab.Malpractice	0	1,716	30	0	0	0	0	0	0	0	0	1,746	26
27	Other (specify):*	(940)	0	6,442	0	0	0	0	0	0	0	0	5,502	27
28	**TOTAL General Administration**	(19,931)	2,023	(13,208)	0	(277)	0	0	0	0	0	0	(31,393)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,970)	2,023	283	(1,189)	(480)	984	(35)	49	0	0	0	(17,335)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Springs # 0047191 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,694)	53,327	3,537	0	0	0	0	0	0	0	0	52,170	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	11,474	60,823	7,574	0	0	0	0	0	0	0	0	79,871	32
33	Real Estate Taxes	0	33,402	645	0	0	0	0	0	0	0	0	34,047	33
34	Rent-Facility & Grounds	0	(148,941)	0	0	0	0	0	0	0	0	0	(148,941)	34
35	Rent-Equipment & Vehicles	0	0	4,551	0	0	0	0	0	0	0	0	4,551	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,780	(1,389)	16,307	0	0	0	0	0	0	0	0	21,698	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	(5,975)	19	0	0	0	0	0	0	(5,956)	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	(5,975)	19	0	0	0	0	0	0	(5,956)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,190)	634	16,590	(7,164)	(461)	984	(35)	49	0	0	0	(1,593)	45

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 148,941	Alden Trails II, LLC	0.00%	$	$ (148,941)	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		33,402	33,402	4
5	V	26	General Insurance Expense		Alden Trails II, LLC		1,716	1,716	5
6	V	32	Interest - Mortgage		Alden Trails II, LLC		77,493	77,493	6
7	V	30	Depreciation		Alden Trails II, LLC		53,327	53,327	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 Exprense		Alden Trails II, LLC		1,469	1,469	11
12	V	32	Gain/Loss on FMV of SWAP	18,139	Alden Trails II, LLC			(18,139)	12
13	V								13
14	Total			$ 167,080			$ 167,714	$ * 634	14

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Alden Management Services, Inc.	0.00%	$ 395	$ 395	15
16	V	24	Trav & Seminar		Alden Management Services, Inc.		156	156	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,529	1,529	17
18	V	26	Insurance		Alden Management Services, Inc.		30	30	18
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		315	315	19
20	V	30	Depreciation		Alden Management Services, Inc.		3,537	3,537	20
21	V	33	Real Estate Tax		Alden Management Services, Inc.		645	645	21
22	V	35	Rent-Equip & Vehicles		Alden Management Services, Inc.		4,551	4,551	22
23	V	32	Interest		Alden Management Services, Inc.		7,574	7,574	23
24	V	1	Dietary		Alden Management Services, Inc.		322	322	24
25	V	3	Housekeeping		Alden Management Services, Inc.		794	794	25
26	V	7	Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		801	801	26
27	V	10	Nurs & Med Records Salary		Alden Management Services, Inc.		6,606	6,606	27
28	V	15	Employee Benefits-Health Care		Alden Management Services, Inc.		795	795	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		18,150	18,150	29
30	V	27	Employee Benefits-Admin		Alden Management Services, Inc.		6,442	6,442	30
31	V	19	Professional Fees	85,083	Alden Management Services, Inc.		16,951	(68,132)	31
32	V	21	Gen'l & Admin	6,480	Alden Management Services, Inc.		34,782	28,302	32
33	V	6	Repair & Maint	6,275	Alden Management Services, Inc.		10,053	3,778	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 97,838			$ 114,428	$ * 16,590	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consult.	$ 3,600	Prism Health Care Sevices, Inc.	0.00%	$ 2	$ (3,598)	15
16	V	1	Dietary Salary		Prism Health Care Sevices, Inc.		1,868	1,868	16
17	V	2	Tube feeding	9,356	Prism Health Care Sevices, Inc.		5,585	(3,771)	17
18	V	10	Equip. Rental	360	Prism Health Care Sevices, Inc.		615	255	18
19	V	39	Ancillary supplies	18,904	Prism Health Care Sevices, Inc.		7,895	(11,009)	19
20	V	1	Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		735	735	20
21	V	2	Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		2,578	2,578	21
22	V	10	Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		744	744	22
23	V	39	Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		5,034	5,034	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			$ 32,220			$ 25,056	$ * (7,164)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 2,909	Forum Extended Care Services II, Inc.	0.00%	$ 2,706	$ (203)	15
16	V	39	I.V.		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care Products	514	Forum Extended Care Services II, Inc.		478	(36)	17
18	V	10	House Stock	2,529	Forum Extended Care Services II, Inc.		2,353	(176)	18
19	V	10	Pharm Consult	384	Forum Extended Care Services II, Inc.		357	(27)	19
20	V	22	Employee Vaccinations	277	Forum Extended Care Services II, Inc.			(277)	20
21	V	39	Employee Vaccinations		Forum Extended Care Services II, Inc.		258	258	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,613			$ 6,152	$ * (461)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Therapy	$ 4,876	Community Physical Therapy & Associates, Ltd.	0.00%	$ 5,860	$ 984	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			$ 4,876			$ 5,860	$ * 984	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repair & Maintenance	$ 5,553	Alden Bennett Construction Company, Inc.	0.00%	$ 5,518	$ (35)	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			$ 5,553			$ 5,518	$ * (35)	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repair & Maintenance	$ 173	Alden Design Group, Inc.	0.00%	$ 222	$ 49	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			$ 173			$ 222	$ * 49	39

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	FECS of Central Illino	Chicago	Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomingdale	Alden Management Se	Chicago	Management	5
6			Alden Terrace of McHenry Rehabilitation and F	McHenry	Alden Gardens of Bloo	Bloomingdale	Supportive Living F	6
7			Wentworth Rehabilitation and Health Care Cen	Chicago	Alden Garden Courts (	DesPlaines	Assisted Living/Alzh	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health (	Bloomingdale	Alden Gardens of Wat	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingdale	Prism Health Care Ser	Schaumburg	Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health (	Orland Park	Community Physical T	Addison	Therapy Provider	11
12			Princeton Rehabilitation and Health Care Cent	Chicago	Alden Bennett Constru	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingdale	Fort Medical Equipme	Fort Atkinson, WI	Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, I	Chicago	Design & Engineerir	14
15			Alden Trails, Inc.	Bloomingdale	Achieve Recovery and	Elmhurst	Rehab-substance ab	15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for S	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health (	Skokie	Family Home Health S	Addison	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.	Bloomingdale				25
26			Alden Village North, Inc.	Chicago				26
27			Alden Estates of Skokie, Inc.	Skokie				27
28			Alden Estates of Countryside, Inc.	Jefferson, WI				28
29			Alden Estates of Shorewood, Inc.	Shorewood, IL				29
30			Alden - Long Grove Rehabilitation and Health C	Long Grove				30

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg A.	Chairman-Board of I	Chairman	100.00	184,186	0.176	0.44	Salary	$ 814	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,560	0.176	0.44	Salary	440	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,560	0.176	0.44	Salary	440	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	115,977	0.176	0.44	Salary	512	17-7	4
5	Audra Elisco E.	Training Coordinator	Train employees	0.00	61,993	0.176	0.44	Salary	274	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	147,955	0.1276	0.44	Salary	654	6-7	6
7	A. Floyd Schlossberg is the Chairman of the Board of Directors, Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10	D. Ina Schlossberg is the wife of Floyd Schlossberg. Ina is on the Board of Directors and participates in the general operations of the company.										10
11	E. Audra Elisco is the daughter of Floyd Schlossberg. Audra is a training coordinator for our Quality Assurance Program.										11
12	F. Randi Schlossberg-Schullo is the daughter of Floyd Schlossberg. Randi is President of Alden Manangement Services, Inc.										12
13								TOTAL	$ 3,134		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: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,288,358	34	$ 89,742	$	5,666	$ 395	1
2	24	Trav & Seminar	Patient Days	1,288,358	34	35,559		5,666	156	2
3	25	Other Admin Travel	Patient Days	1,288,358	34	347,560		5,666	1,529	3
4	26	Insurance	Patient Days	1,288,358	34	6,826		5,666	30	4
5	20	Dues & Subscriptions	Patient Days	1,288,358	34	71,705		5,666	315	5
6	30	Depreciation	No of Providers/usage	34	34	140,451		1	3,537	6
7	33	Real Estate Tax	Patient Days/usage	1,288,358	34	172,398		5,666	645	7
8	35	Rent-Equip & Vehicle	Patient Days	1,288,358	34	1,034,867		5,666	4,551	8
9	32	Interest	Patient Days/usage	1,288,358	34	1,892,273		5,666	7,574	9
10	1	Dietary Salary	Patient Days	1,288,358	34	73,278	73,278	5,666	322	10
11	3	Housekeeping Salary	Patient Days	1,288,358	34	180,508	180,508	5,666	794	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,288,358	34	182,054		5,666	801	12
13	10	Nurs & Med Records Salary	Patient Days	1,288,358	34	1,519,466	1,519,466	5,666	6,606	13
14	15	Employee Benefits -Health Care	Patient Days	1,288,358	34	180,775		5,666	795	14
15	17	Administrative Salary	Patient Days/usage	1,288,358	34	4,500,263	4,500,263	5,666	18,150	15
16	27	Employee Benefits - Admin	Patient Days	1,288,358	34	1,464,772		5,666	6,442	16
17	19	Professional fees	Patient Days	1,288,358	34	1,094,912	881,977	5,666	16,951	17
18	21	Gen'I & Admin	Patient Days	1,288,358	34	7,908,785	6,929,587	5,666	34,782	18
19	6	Repair & Maint.	Patient Days	1,288,358	34	1,864,177	1,276,432	5,666	10,053	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 22,760,371	$ 15,361,511		$ 114,428	25

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Bank (GI 2513/2021/7035)		X	Mortgage	Varies	8/29/12	$ 1,520,000	$ 1,379,683	9/05/2022	3.5000	$ 56,063	1
2												2
3	FMV of Derivative		X	Rate Swap interest							21,430	3
4	Amort of Fin Fees (GL 7105)		X	Refinancing							1,469	4
5	Insurance Interest (GL7053)		x	Malpractice Insurance							252	5
	Working Capital											
6	Related party-AMS		x	Working Capital							7,574	6
7												7
8												8
9	TOTAL Facility Related						$ 1,520,000	$ 1,379,683			$ 86,788	9
	B. Non-Facility Related*											
10	Interest Income (GL 4975)		x									10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,520,000	$ 1,379,683			$ 86,788	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.)**

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	35,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	33,802	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,398)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	33,402	7
Plus: Related Party Taxes - See Pg RE_Tax	$	645	
Total Real Estate Tax Expense, Sch V, Line 33	$	34,047	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	30,863	8
	2012	31,963	9
	2013	34,394	10
	2014	34,127	11
	2015	33,802	12

The current year accrual is based on an estimated 3% increase of the prior year tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached (Supplement)	Related party-Alden Management	$ 146,629.00	$ 645.00
2.	02-23-300-024	Alden Trails II LLC	$ 33,802.46	$ 33,802.46
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,431.46	$ 34,447.46

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	nursing facility	22,035	2006	$ 398,630	1
2					2
3	TOTALS	22,035		$ 398,630	3

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2006		$ 1,583,599	$ 39,590	40	$ 39,590	$	$ 405,797	4
5			2006		69,510	1,738	40	1,738		17,814	5
6			2006		20,156	504	40	504		5,376	6
7											7
8											8
	Improvement Type**										
9	Wiring			2006	840	42	20	42		431	9
10											10
11	Drywall Carpentry			2007	18,677	1,245	15	1,245		12,036	11
12	Plumb, Floor Prep, Fencing-ABC Renovation			2007	23,127	2,312	10	2,312		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 & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,715,910	$ 45,431		$ 45,431	$	$ 464,581	1
2	Forum Prof Ctr: Remodeling	1979	15,638		20			15,638	2
3	Forum Prof Ctr: Build Improv - multiple	1980	30,457		15			30,457	3
4	Forum Prof Ctr: Tennant Improv	1986	961		13			961	4
5	Forum Prof Ctr: AMS remodel	1990	6,532		10			6,532	5
6	Forum Prof Ctr: Roof	1994	3,445		16			3,445	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,215		16			1,215	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,919		10			1,919	8
9	Forum Prof Ctr: Remodel/electrical	2001	748		7			748	9
10	Forum Prof Ctr: bathroom remodel	2002	661		5			661	10
11	Forum Prof Ctr: remodel suites/etc.	2003	850		9			850	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,616		7			2,616	12
13	Forum Prof Ctr: Suite renovation	2005	528	(45)	10	(45)		528	13
14	Forum Prof Ctr: Superior installations, etc.	2006	126		4			126	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	508		7			508	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	436		7			436	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	887	95	10	95		626	17
18	Forum Prof Ctr: Building Renovations	2010	1,511		5			1,511	18
19	Forum Prof Ctr: Building Renovations	2011	6,625	532	10	532		3,327	19
20	Forum Prof Ctr: Building Renovations	2012	288	39	15	39		195	20
21	Forum Prof Ctr: Building Renovations	2013	432	62	7	62		175	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	440	44		44		100	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	455	121	10-Jan	121		172	23
24	Alden Mgt Servs: Remodel suites	1993	6,963		13			6,963	24
25	Alden Mgt Servs: Remodel suites	2002	290		11			290	25
26	Alden Mgt Servs: Remodel suites	2003	6,295					6,295	26
27	Alden Mgt Servs: Motor Controller PC Board	2014	86	17		17		44	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,806,822	$ 46,296		$ 46,296	$	$ 550,919	34

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 176,311	$ 17,676	$ 17,676	$	varies	$ 112,746	71
72	Current Year Purchases	18,885	858	858		varies	857	72
73	Fully Depreciated Assets	148,146	3,949	3,949		varies	148,146	73
74								74
75	TOTALS	$ 343,342	$ 22,483	$ 22,483	$		$ 261,749	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	related party-AMS	various	1998-2004	4,026				3	4,026	79
80	TOTALS			$ 4,026	$	$	$		$ 4,026	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,552,820	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,779	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,779	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)	$ 816,694	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: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1/1/2007
Ending 11/1/2026

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2017	$ varies
13.	12/31/2018	$ varies
14.	12/31/2019	$ varies

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 2,031 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	related party-PG 6A	various	$ 149.00	$ 1,788	17
18					18
19	Auto lease - gl 6890	various	0.00		19
20					20
21	TOTAL		$ 149.00	$ 1,788	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nursing on site.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				2,964		2,964	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						13,407		13,407	13
14	TOTAL			$		$	$ 16,371		$ 16,371	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.

Alden Springs, Inc.
PA pg 16A Ref. Line 39 Details
For the Twelve Months Ending December 31, 2016

XIV. Special Services (Direct Cost)			Page 16 Col 5: PT,OT, & ST Col 6: Supplies
Line Service	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	$0.00
2. ST	39-3	To Col 5	0.00
3.			
4. PT	39-3	To Col 5	0.00
5.			
6.			
7.			
8. Less PT, OT, & ST costs reclassed to Line 10A for "DD type facilities			0.00
			0.00
Less: OT, ST, & PT costs - reclassed to 10A for DD facilities			0.00
			0.00
Phamacy Supplies per GL			2,908.65
Manual Input from Related Party- Forum Drugs & Vaccinations			55.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	2,963.65
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	
Other			19,417.91
Manual Input: Related Party - Prism			(5,975.00)
Manual Input: Related Party FECII - I.V.			0.00
Manual Input: Related Party FECII - Wound Care Product			(36.00)
Oxygen, from reclass worksheet (Pg 4A)			
13. Col 6: Supplies Total		To Col 6	13,406.91
13. Total Line 13, Column 8			13,406.91
14. Total			16,370.56

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs **#** 0047191 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 20,085	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500)	239,851	239,851	3
4	Supply Inventory (priced at)	561	561	4
5	Short-Term Investments			5
6	Prepaid Insurance		1,470	6
7	Other Prepaid Expenses	1,721	1,721	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 242,133	$ 263,688	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,674,106	14
15	Leasehold Improvements, at Historical Cost	23,431	23,431	15
16	Equipment, at Historical Cost	129,349	314,498	16
17	Accumulated Depreciation (book methods)	(79,038)	(666,929)	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 **(Refinan.Fee)**		8,446	22
23	Other(specify): Due from Affiliate, Wage Allocat	56,115	56,115	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 129,857	$ 1,808,297	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 371,990	$ 2,071,985	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 142,955	$ 142,955	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,553	8,553	28
29	Short-Term Notes Payable		37,937	29
30	Accrued Salaries Payable	84,987	84,987	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,070	3,070	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,800	32
33	Accrued Interest Payable		6,487	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp/Ins,d/t PA,SaleTx,etc.	35,977	35,977	36
37	Due to Affiliates	90,388	157,162	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 365,930	$ 511,927	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,341,746	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates-Wage allocation	40,290	40,290	43
44	FMV of Derivative		8,963	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 40,290	$ 1,391,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 406,220	$ 1,902,927	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (34,230)	$ 169,058	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 371,990	$ 2,071,985	48

***(See instructions.)**

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 209,249	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 209,249	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(187,404)	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) **Prior years shared salaries**	(56,075)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (243,479)	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)**	$ (34,230)	24 *

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,206,593	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,206,593	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training	261,227	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261,227	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,467,835	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	215,493	31
32	Health Care	626,092	32
33	General Administration	283,959	33
	B. Capital Expense		
34	Ownership	174,044	34
	C. Ancillary Expense		
35	Special Cost Centers	283,554	35
36	Provider Participation Fee	72,098	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,655,239	40
41	**Income before Income Taxes (line 30 minus line 40)****	(187,404)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (187,404)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,206,593	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,206,593	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: 01/01/2016 Ending: 12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,636	4,844	216,999	44.80	3
4	Licensed Practical Nurses	2,580	2,811	72,825	25.91	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	520	520	11,151	21.44	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,314	4,442	61,548	13.86	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	520	520	9,336	17.95	18
19	Laundry					19
20	Administrator	520	520	19,419	37.34	20
21	Assistant Administrator					21
22	Other Administrative	333	333	12,785	38.39	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)	20,193	21,639	272,063	12.57	30
31	Medical Records					31
32	Other Health C: Facility Manager	1,024	1,024	24,705	24.13	32
33	Other(specify) Behavioral Health	347	347	12,304	35.46	33
34	TOTAL (lines 1 - 33)	34,987	37,000	$ 713,135 *	$ 19.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	300/Monthly	$ 3,608	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	3	165	11-3	44
45	Social Service Consultant	5	700	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	$ 8,457		49

C. CONTRACT NURSES

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

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Rodriguez	Administrator	0	$ 19,419
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 19,419

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services, Inc.	consulting fee	$ 61,083
AMS (Eliminated)	Allocated Legal Fees	24,000
BDO, USA	Accounting fee	1,308
Baker Tilly Virchow Krause	Accounting fee	2,547
Alden Group-MidCap	Accounting fee/Legal Fees	240
Simandl Law Group	Professional Fees	487
Gozdecki,Del Guidice/Simndl Law Gı	Legal Fees	144
MPRO Administration Org	Professional Fees	1,750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 91,560

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,027
Unemployment Compensation Insurance	2,031
FICA Taxes	45,562
Employee Health Insurance	8,698
Employee Meals	3,441
Illinois Municipal Retirement Fund (IMRF)*	
Dental/Life Insurance	298
Employee Drug Tests	128
Misc Payroll Costs/401K Match	1,778
Employee Relations	388
Employee Vaccinations	277
Related Party -Forum Pharmacy	(277)
TOTAL (agree to Schedule V, line 22, col.8)	$ 84,351

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	108
Health Care Worker Background Check	
(Indicate # of checks performed 2)	
Patient Background Checks	20
Health care council of ILL	1,536
Collaborative Healthcare	300
Surety bond fees-Marsh USA Inc.	213
Citi/Secretary of State-Annual Report	460
Related Party-AMS	315
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,952

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party-AMS	156
Seminar Expense	
IL Council of Long Term Care	31
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 187

* Attach copy of IMRF notifications

**See instructions.

Alden Springs, Inc.
Legal Fee Support
2016

Legal Fees Reported on Pg 21, Section C:	24,592
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)
+ Add Back voided invoice of prior year, if any	
Allowable Legal Fees	592

In Detail:

Vendor Name	Invoice Date	Amount
Simandl Law Group LLc	11/17/16	387
Simandl Law Group LLc	12/13/16	21
MIDCAP Allo.Legal Fees 01/16	01/31/16	3
MIDCAP Allo.Legal Fees 03/16	03/31/16	37
Gozdecki, Del Giudice, Americus,Farka	12/24/15	144
TOTAL ALLOWABLE LEGAL FEES		**592**

Vendor Name	Invoice Date	Amount
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		**-**

Vendor Name	Invoice Date	Amount
AMS Legal exp Allocation 2016	1/1/2016	2,000
AMS Legal exp Allocation 2016	02/01/16	2,000
AMS Legal exp Allocation 2016	03/01/16	2,000
AMS Legal exp Allocation 2016	04/01/16	2,000
AMS Legal exp Allocation 2016	05/01/16	2,000
AMS Legal exp Allocation 2016	06/01/16	2,000
AMS Legal exp Allocation 2016	07/01/16	2,000
AMS Legal exp Allocation 2016	08/01/16	2,000
AMS Legal exp Allocation 2016	09/01/16	2,000
AMS Legal exp Allocation 2016	10/01/16	2,000
AMS Legal exp Allocation 2016	11/01/16	2,000
AMS Legal exp Allocation 2016	12/01/16	2,000
TOTAL Allocated Legal Fees		**24,000**

Total Legal Cost	**24,592**

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? C.N.A-Yes, RN/LPNs-N

(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. $ 10,161 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. $ 72,098
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 3,441 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