

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

I. IDPH License ID Number: 0042069

Facility Name: Alden of Old Town East

Address: 108 South First St Bloomington 60108
 Number City Zip Code

County: Dupage

Telephone Number: (630) 671-1703 **Fax #** (630) 671-1706

HFS ID Number: _____

Date of Initial License for Current Owners: 05/09/98

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 01/01/2017 to 12/31/2017 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) _____
	(Type or Print Name) <u>Randi Schlossberg-Schullo</u> (Date) _____
Paid Preparer	(Title) <u>President, Alden Management Services, Inc.</u>
	(Signed) _____ (Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) _____
	(Telephone) <u>()</u> Fax # <u>()</u>

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 of Old Town East

0042069 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	5,375	343		5,718	13
14	TOTALS	5,375	343		5,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.91%

D. How many bed reserve days during this year were paid by the Department?
91 (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 07/06/98

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	61,156	3,156	3,900	68,212	33	68,245	(898)	67,347		1
2	Food Purchase		46,097		46,097	(4,328)	41,769	988	42,757		2
3	Housekeeping	33,725	5,564		39,289	567	39,856	945	40,801		3
4	Laundry		4,559		4,559		4,559		4,559		4
5	Heat and Other Utilities			24,205	24,205		24,205	10	24,215		5
6	Maintenance			43,142	43,142	1,933	45,075	11,263	56,338		6
7	Other (specify):* related party			300	300		300	1,059	1,359		7
8	TOTAL General Services	94,881	59,376	71,547	225,804	(1,795)	224,009	13,367	237,376		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	409,424	18,477	1,124	429,025	534	429,559	7,089	436,648		10
10a	Therapy			6,173	6,173		6,173	899	7,072		10a
11	Activities	20,902	1,275	842	23,019		23,019		23,019		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							1,025	1,025		15
16	TOTAL Health Care and Programs	430,326	19,752	11,739	461,817	534	462,351	9,013	471,364		16
	C. General Administration										
17	Administrative	17,694			17,694		17,694	20,241	37,935		17
18	Directors Fees										18
19	Professional Services			95,815	95,815		95,815	(70,840)	24,975		19
20	Dues, Fees, Subscriptions & Promotions			4,600	4,600		4,600	(1,314)	3,286		20
21	Clerical & General Office Expenses	26,780	1,092	24,907	52,779		52,779	26,944	79,723		21
22	Employee Benefits & Payroll Taxes			100,486	100,486	3,194	103,680	(336)	103,344		22
23	Inservice Training & Education										23
24	Travel and Seminar			61	61		61	137	198		24
25	Other Admin. Staff Transportation			460	460		460	1,510	1,970		25
26	Insurance-Prop.Liab.Malpractice			21,658	21,658		21,658	1,438	23,096		26
27	Other (specify):* related party			(2,760)	(2,760)		(2,760)	10,831	8,071		27
28	TOTAL General Administration	44,474	1,092	245,227	290,793	3,194	293,987	(11,389)	282,598		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	569,681	80,220	328,513	978,414	1,933	980,347	10,991	991,338		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 of Old Town East

#0042069

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	
	D. Ownership											
30	Depreciation			3,528	3,528	(1,933)	1,595	38,248	39,843			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,006	11,006		11,006	30,457	41,463			32
33	Real Estate Taxes			17,925	17,925	(17,925)		16,421	16,421			33
34	Rent-Facility & Grounds			75,912	75,912	17,925	93,837	(93,837)				34
35	Rent-Equipment & Vehicles			1,660	1,660		1,660	4,122	5,782			35
36	Other (specify):* MIP							5,518	5,518			36
37	TOTAL Ownership			110,031	110,031	(1,933)	108,098	929	109,027			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		11,584		11,584		11,584	(4,719)	6,865			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,368	75,368		75,368		75,368			42
43	Other (specify):* Day Training			284,721	284,721		284,721		284,721			43
44	TOTAL Special Cost Centers		11,584	360,089	371,673		371,673	(4,719)	366,954			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	569,681	91,804	798,633	1,460,118		1,460,118	7,201	1,467,319			45

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

Alden of Old Town East
 Period Beginning: 01/01/2017
 Period Ending: 12/31/2017

IDPH License No. 0

Reclassifications - Pages 3 & 4

From Line	To Line	Amount	Description	
2		(4,328)	Employee Meals	Entered
	22	4,328	Employee Meals	Entered
22		(1,134)	Uniform Reclass	Entered
	1	33	Uniform Reclass	Entered
	3	567	Uniform Reclass	Entered
	4		Uniform Reclass	Entered
	6		Uniform Reclass	Entered
	10	534	Uniform Reclass	Entered
	11		Uniform Reclass	Entered
	21		Uniform Reclass	Entered
10		None	Oxygen Cost Reclass	Entered
	39	None	Oxygen Cost Reclass	Entered
33		(15,965)	Rent - Real Estate Tax on associated landowner (Pg 6)	
	34	15,965	Rent - Real Estate Tax on associated landowner (Pg 6)	
30		(1,933)	Reclass Depreciation on Painting	
	6	1,933	Reclass Depreciation on Painting	

Also, check your reclasses on last year's file, as there may be reclasses specific to your facility.

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	(4,071)	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	(165)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,097)	21		17
18	Fines and Penalties				18
19	Entertainment				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	2,760	27		24
25	Fund Raising, Advertising and Promotional	(1,009)	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)	\$ (5,032)		\$	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)	20,192	Pg 6s	34
35	Other- Attach Schedule	(7,959)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,233		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 7,201		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Alden of Old Town East

ID# 0042069

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	\$ (381)	5	1
2	Intercompany Interest	(10,728)	32	2
3				3
4	Elim Deprec Exp on Pg 12 items under \$2,500 -	(1,203)	30	4
5	Elim Deprec Exp on Pg 13 items under \$2500 -	(4,268)	30	5
6	Expense Pg 12 items under \$2,500 - curr yr purchs +	1,889	6	6
7	Expense Pg 13 items under \$2,500 - curr yr purchs +	7,918	6	7
8				8
9	Elim ABC Deprec Exp from Pg 12 series -	11	30	9
10	Reconcile Depreciation expense	(1,197)	30	10
11	Marketing Manger & Aides		21	11
12	Elim portion of benefits for marketing 'ees		22	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	(7,959)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town East

0042069

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	322	(1,220)	0	0	0	0	0	0	0	(898)	1
2	Food Purchase	(165)	0	0	1,153	0	0	0	0	0	0	0	988	2
3	Housekeeping	0	0	945	0	0	0	0	0	0	0	0	945	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(381)	0	391	0	0	0	0	0	0	0	0	10	5
6	Maintenance	5,736	0	5,457	0	0	0	(9)	79	0	0	0	11,263	6
7	Other (specify):*	0	0	1,059	0	0	0	0	0	0	0	0	1,059	7
8	TOTAL General Services	5,190	0	8,174	(67)	0	0	(9)	79	0	0	0	13,367	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	6,797	440	(148)	0	0	0	0	0	0	7,089	10
10a	Therapy	0	0	0	0	0	899	0	0	0	0	0	899	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	1,025	0	0	0	0	0	0	0	0	1,025	15
16	TOTAL Health Care and Programs	0	0	7,822	440	(148)	899	0	0	0	0	0	9,013	16
	C. General Administration													
17	Administrative	0	0	20,241	0	0	0	0	0	0	0	0	20,241	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,900	(73,740)	0	0	0	0	0	0	0	0	(70,840)	19
20	Fees, Subscriptions & Promotions	(1,459)	0	145	0	0	0	0	0	0	0	0	(1,314)	20
21	Clerical & General Office Expenses	(2,097)	102	28,939	0	0	0	0	0	0	0	0	26,944	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(336)	0	0	0	0	0	0	(336)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	137	0	0	0	0	0	0	0	0	137	24
25	Other Admin. Staff Transportation	0	0	1,510	0	0	0	0	0	0	0	0	1,510	25
26	Insurance-Prop.Liab.Malpractice	0	1,406	32	0	0	0	0	0	0	0	0	1,438	26
27	Other (specify):*	2,760	0	8,071	0	0	0	0	0	0	0	0	10,831	27
28	TOTAL General Administration	(796)	4,408	(14,665)	0	(336)	0	0	0	0	0	0	(11,389)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	4,394	4,408	1,331	373	(484)	899	(9)	79	0	0	0	10,991	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town East

0042069

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	(6,657)	42,123	2,782	0	0	0	0	0	0	0	0	38,248	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,728)	29,298	11,887	0	0	0	0	0	0	0	0	30,457	32
33	Real Estate Taxes	0	15,965	456	0	0	0	0	0	0	0	0	16,421	33
34	Rent-Facility & Grounds	0	(93,837)	0	0	0	0	0	0	0	0	0	(93,837)	34
35	Rent-Equipment & Vehicles	0	0	4,122	0	0	0	0	0	0	0	0	4,122	35
36	Other (specify):*	0	5,518	0	0	0	0	0	0	0	0	0	5,518	36
37	TOTAL Ownership	(17,385)	(933)	19,247	0	0	0	0	0	0	0	0	929	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	(4,892)	173	0	0	0	0	0	0	(4,719)	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	(4,892)	173	0	0	0	0	0	0	(4,719)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(12,991)	3,475	20,578	(4,519)	(311)	899	(9)	79	0	0	0	7,201	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 93,837	Alden of Bloomingdale Limited Partnership	0.00%	\$	\$ (93,837)	1
2	V	32 Interest Income - RR	13	Alden of Bloomingdale Limited Partnership			(13)	2
3	V	32 Interest Income		Alden of Bloomingdale Limited Partnership				3
4	V	21 Corporate Annual Report Fee		Alden of Bloomingdale Limited Partnership		102	102	4
5	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,900	2,900	5
6	V	6 Repairs and Maintenance		Alden of Bloomingdale Limited Partnership				6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		15,965	15,965	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,406	1,406	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		5,518	5,518	9
10	V	32 Interest - Mortgage/ IOD		Alden of Bloomingdale Limited Partnership		27,593	27,593	10
11	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership				11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		42,123	42,123	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		1,718	1,718	13
14	Total		\$ 93,850			\$ 97,325	\$ *	3,475 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%	\$ 391	\$	391	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		137		137	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,510		1,510	17
18	V	26 Insurance		Alden Management Services, Inc.		32		32	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		145		145	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,782		2,782	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		456		456	21
22	V	35 Rent- Equipment & Vehicles		Alden Management Services, Inc.		4,122		4,122	22
23	V	32 Interest		Alden Management Services, Inc.		11,887		11,887	23
24	V	1 Dietary		Alden Management Services, Inc.		322		322	24
25	V	3 Housekeeping		Alden Management Services, Inc.		945		945	25
26	V	7 Employee Benefits- Gen'l Services		Alden Management Services, Inc.		1,059		1,059	26
27	V	10 Nursing & Medical Record Salaries		Alden Management Services, Inc.		6,797		6,797	27
28	V	15 Employee Benefits- Health Care		Alden Management Services, Inc.		1,025		1,025	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		20,241		20,241	29
30	V	27 Employee Benefits- Admin		Alden Management Services, Inc.		8,071		8,071	30
31	V	19 Professional Fees	91,317	Alden Management Services, Inc.		17,577		(73,740)	31
32	V	21 General & Administrative	6,528	Alden Management Services, Inc.		35,467		28,939	32
33	V	6 Repairs & Maintenance	19,719	Alden Management Services, Inc.		25,176		5,457	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 117,564			\$ 138,142	\$ *	20,578	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Consultant	\$ 3,600	Prism Health Care Sevices, Inc.	0.00%	\$	\$(3,600)
16	V	1 Dietary Salary		Prism Health Care Sevices, Inc.		2,043	2,043
17	V	2 Tube Feeding		Prism Health Care Sevices, Inc.			
18	V	10 Equipment Rental	360	Prism Health Care Sevices, Inc.		524	164
19	V	39 Supplies	9,682	Prism Health Care Sevices, Inc.		2,716	(6,966)
20	V	1 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		337	337
21	V	2 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		1,153	1,153
22	V	10 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		276	276
23	V	39 Gen'l & Admin & Benefits		Prism Health Care Sevices, Inc.		2,074	2,074
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		\$ 13,642			\$ 9,123	\$ * (4,519)

* 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	\$ 1,228	Forum Extended Care Services II, Inc.	0.00%	\$ 1,134	\$ (94)
16	V	39 I.V.		Forum Extended Care Services II, Inc.			
17	V	39 Wound Care Products	556	Forum Extended Care Services II, Inc.		513	(43)
18	V	10 House Stock	1,543	Forum Extended Care Services II, Inc.		1,425	(118)
19	V	10 Pharm Consultant	384	Forum Extended Care Services II, Inc.		354	(30)
20	V	22 Employee Vaccinations	336	Forum Extended Care Services II, Inc.			(336)
21	V	39 Employee Vaccinations		Forum Extended Care Services II, Inc.		310	310
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		\$ 4,047			\$ 3,736	\$ * (311)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10a Therapy	\$ 6,173	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 7,072	\$ 899	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 6,173			\$ 7,072	\$ *	899	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs and Maintenance	\$ 6,264	Alden Bennett Construction Company, Inc.	0.00%	\$ 6,255	\$ (9)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,264			\$ 6,255	\$ * (9)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Repairs and Maintenance	\$ 361	Alden Design Group, Inc.	0.00%	\$ 440	\$ 79	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		\$ 361			\$ 440	\$ *	79 39

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

Facility Name & ID Number

Alden of Old Town East

0042069

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heather Health Care Center, Inc.	Harvey	The Forum Professional Center, LP		Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care Services II, Inc.		Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	FECS of Central Illinois, Inc.		Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomingtondale	Alden Management Services, Inc.		Management	5
6			Alden Terrace of McHenry Rehabilitation and E	McHenry	Alden Gardens of Bloomingtondale, Inc.		Supportive Living F	6
7			Wentworth Rehabilitation and Health Care Cen	Chicago	Alden Garden Courts of DesPlaines, LLC		Assisted Living/Alzh	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Waterford, LLC		SNF & Alzheimers I	8
9			Alden - Valley Ridge Rehabilitation and Health	Bloomingtondale	Alden Gardens of Waterford, LLC		Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingtondale	Prism Health Care Services, Inc.		Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health	Orland Park	Community Physical Therapy & Associates, Lt		Therapy Provider	11
12			Princeton Rehabilitation and Health Care Cent	Chicago	Alden Bennett Construction Company, Inc.		General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipment, LLC		Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, Inc.		Design & Engineeri	14
15			Alden Trails, Inc.	Bloomingtondale				15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for Seniors, Inc		Private duty care	16
17			Alden - North Shore Rehabilitation and Health	(Skokie	Family Home Health Services, Inc.		Home health & hosp	17
18			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				18
19			Alden Estates of Evanston, Inc.	Evanston				19
20			Alden - Alma Nelson Manor, Inc.	Rockford				20
21			Alden - Park Strathmoor, Inc.	Rockford				21
22			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				22
23			Alden Estates of Barrington, Inc.	Barrington				23
24			Alden of Waterford, LLC	Aurora				24
25			Alden Springs, Inc.	Bloomingtondale				25
26			Alden Village North, Inc.	Chicago				26
27			Alden Estates of Skokie, Inc.	Skokie				27
28			Alden Estates of Countryside, Inc.	Jefferson, WI				28
29			Alden Estates of Shorewood, Inc.	Shorewood, IL	Alden Courts of Shorewood, Inc.		SNF	29
30			Alden - Long Grove Rehabilitation and Health	C Long Grove				30

Facility Name & ID Number Alden of Old Town East # 0042069 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	184,199	0.172	0.43	Salary	\$ 801	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,567	0.172	0.43	Salary	433	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,567	0.172	0.43	Salary	433	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	114,399	0.172	0.43	Salary	498	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	62,685	0.172	0.43	Salary	273	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	184,199	0.129	0.43	Salary	801	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	\$ 3,239		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 of Old Town East

0042069

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,320,269	35	\$ 90,340	\$ 5,718	\$ 391	1
2	24	Trav & Seminar	Patient Days	1,320,269	35	31,744	5,718	137	2
3	25	Other Admin Travel	Patient Days	1,320,269	35	348,589	5,718	1,510	3
4	26	Insurance	Patient Days	1,320,269	35	7,373	5,718	32	4
5	20	Dues & Subscriptions	Patient Days	1,320,269	35	33,588	5,718	145	5
6	30	Depreciation	No of Providers/usage	35	35	119,326	1	2,782	6
7	33	Real Estate Tax	Patient Days/usage	1,320,269	35	129,699	5,718	456	7
8	35	Rent-Equip & Vehicle	Patient Days	1,320,269	35	951,681	5,718	4,122	8
9	32	Interest	Patient Days/usage	1,320,269	35	2,187,612	5,718	11,887	9
10	1	Dietary Salary	Patient Days	1,320,269	35	74,426	74,426	322	10
11	3	Housekeeping Salary	Patient Days	1,320,269	35	218,203	218,203	945	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,320,269	35	244,557	5,718	1,059	12
13	10	Nurs & Med Records Salary	Patient Days	1,320,269	35	1,647,662	1,647,662	6,797	13
14	15	Employee Benefits -Health Care	Patient Days	1,320,269	35	236,654	5,718	1,025	14
15	17	Administrative Salary	Patient Days/usage	1,320,269	35	4,903,376	4,750,005	20,241	15
16	27	Employee Benefits - Admin	Patient Days	1,320,269	35	1,863,643	5,718	8,071	16
17	19	Professional fees	Patient Days	1,320,269	35	1,119,817	920,527	17,577	17
18	21	Gen'I & Admin	Patient Days	1,320,269	35	8,189,318	7,151,399	35,467	18
19	6	Repair & Maint.	Patient Days	1,320,269	35	1,823,498	1,358,004	25,176	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 24,221,106	\$ 16,120,226	\$ 138,142	25

Facility Name & ID Number Alden of Old Town East

0042069

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge		x	Mortgage	\$4,317.00	9/1/12	\$ 1,212,967	\$ 1,092,592	12/31/47	2.5000	\$ 27,593	1								
2												2								
3	Amort of Fin Fees (GL 7105)		x	Refinancing							1,718	3								
4	Insurance Interest (GL7053)		x	Medical Malpractice							278	4								
5												5								
Working Capital																				
6	Related party-AMS		x	Working Capital							11,887	6								
7												7								
8												8								
9	TOTAL Facility Related				\$4,317.00		\$ 1,212,967	\$ 1,092,592			\$ 41,476	9								
B. Non-Facility Related*																				
10	Interest Income (GL 4975)		x									10								
11	Interest Income R.R.		x								(13)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (13)	14								
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,092,592			\$ 41,463	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,518 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1.	Real Estate Tax accrual used on 2016 report.			\$	<u>16,037</u>	1	
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<u>15,757</u>	2	
3.	Under or (over) accrual (line 2 minus line 1).			\$	<u>(280)</u>	3	
4.	Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>16,245</u>	4	
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5	
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>15,965</u>	7	
Real Estate Tax History:		Plus: Related Party Taxes - See Pg RE_Tax		\$	<u>456</u>		
		Total Real Estate Tax Expense, Sch V, Line 33		\$	<u>16,421</u>		
Real Estate Tax Bill for Calendar Year:	2012	<u>15,173</u>	8	FOR BHF USE ONLY			
	2013	<u>15,813</u>	9	13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
	2014	<u>16,032</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2015	<u>15,579</u>	11	15	LESS REFUND FROM LINE 6	\$	15
	2016	<u>15,757</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden of Old Town East COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042069

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>456.00</u>
2. <u>02-15-201-020</u>	<u>Nursing Home Facility</u>	\$ <u>15,757.00</u>	\$ <u>15,757.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>121,129.00</u></u>	\$ <u><u>16,213.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Alden of Old Town East

0042069 Report Period Beginning:

01/01/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: nursing facility, 14,400, 1995, \$ 150,686, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 14,400, (blank), \$ 150,686, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1997	1997	\$ 934,861	\$ 23,372	40	\$ 23,372	\$	\$ 456,370	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	TV Modules		1999	1,775		5			1,775	9
10	Sprinkler system		2001	2,345		10			2,345	10
11										11
12	ABC Counter Tops		2003	8,091		10			8,091	12
13	ABC roof repair		2003	1,685		10			1,685	13
14										14
15	Central States Automati(Sprinkler Repair)		2005	1,614		10			1,614	15
16	Alden Bennett Const(Door Installation)		2005	1,882		10			1,882	16
17										17
18	ABC - Replace Resident's Room Ceiling		2009	4,749	475	10	475		4,160	18
19										19
20	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC		2011	11,117	556	20	556		3,753	20
21	Valve Inspections/water gauge on valve replaced - USFIRE		2011	3,703		5			3,703	21
22	Sprinkler System/Fire Safety Equipment-Valley Fire		2013	3,103	621	5	621		2,846	22
23										23
24	Sprinkler, Fire Work - ALDBEN		2015	10,015	401	25	401		1,136	24
25										25
26	Replace Tile in Shower Room - ALDBEN		2017	8,905	171	39	171		171	26
27	Replace Tile in Shower Room - ALDBEN		2017	5,424	116	39	116		116	27
28	Replace Tile in Shower Room - ALDBEN		2017	8,160	157	39	157		157	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 of Old Town East

0042069

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,007,429	\$ 25,869		\$ 25,869	\$	\$ 489,804	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	TOTAL (lines 1 thru 33)		\$ 1,086,383	\$ 26,909		\$ 26,909	\$	\$ 578,765	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 12D, Carried Forward		\$ 1,086,383	\$ 26,909		\$ 26,909	\$	\$ 578,765	1
2	Adj for ABC related party profit	2009	(63)	8		8		(63)	2
3	Adj for ABC related party profit	2011	86	6		6		39	3
4	Adj for ABC related party profit	2015	(19)	(2)		(2)		(5)	4
5	Adj for ABC related party profit	2017	(12)	(1)		(1)		(1)	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,086,375	\$ 26,920		\$ 26,920	\$	\$ 578,735	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	\$ 103,165	\$ 12,244	\$ 12,244	\$	varies	\$ 69,771	71
72	Current Year Purchases	66,726	571	571		varies	571	72
73	Fully Depreciated Assets	199,049	108	108		varies	199,049	73
74								74
75	TOTALS	\$ 368,940	\$ 12,923	\$ 12,923	\$		\$ 269,391	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	AMS-Bus/Travel Van	Chev/Lumina/00/Various	1998-2004	\$ 4,634	\$	\$	\$		\$ 4,634	76
77	related party-AMS	various	1998-2004	3,911					3,911	77
78	Bills Auto & Truck	Major Capital Repair	2002	817					817	78
79										79
80	TOTALS			\$ 9,362	\$	\$	\$		\$ 9,362	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,615,363	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,843	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,843	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)	\$ 857,488	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 of Old Town East

0042069

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	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning 12/02/1996

Ending 11/30/2036

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

Fiscal Year Ending Annual Rent

12. 12/31/2018 \$ 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: \$ 2,287 Description: copy machine GL 6861 - \$1,660 and equipment lease GL 6859 - \$627

(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>153.33</u>	\$ <u>1,840</u>	17
18					18
19	<u>Auto lease - gl 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>153.33</u>	\$ <u>1,840</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				1,443		1,443	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					119		119	12
13	Other (specify):	See Pg 16A					5,303		5,303	13
14	TOTAL			\$		\$	6,865		\$ 6,865	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.	Pharmacy Supplies per GL			1,227.00	
	Manual Input from Related Party- Forum Drugs & Vaccinations			216.00	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	1,443.00	
10.					
11.					
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00	
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	119.00	
	Total Exceptional Care (Line 12, Col 8)			119.00	
13.	Other:	See Pg 16A			
13.	Col 5: Manual Input: Related Party - CPT		To Col 5		From Page 6D
	Other			10,238.00	
	Manual Input: Related Party - Prism			(4,892.00)	From Page 6B
	Manual Input: Related Party FECII - I.V.			0.00	From Page 6C
	Manual Input: Related Party FECII - Wound Care Products			(43.00)	From Page 6C
	Oxygen, from reclass worksheet (Pg 4A)			-	
13.	Col 6: Supplies Total		To Col 6	5,303.00	
13.	Total Line 13, Column 8			5,303.00	
14.	Total			6,865.00	

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	162,086	162,086	3
4	Supply Inventory (priced at)	588	588	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,283	6
7	Other Prepaid Expenses	1,465	1,465	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 164,139	\$ 169,422	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		140,913	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	51,321	98,007	15
16	Equipment, at Historical Cost	90,708	313,880	16
17	Accumulated Depreciation (book methods)	(99,525)	(748,209)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		10,218	21
22	Other Long-Term Assets (spe <u>Refinancing Fees</u>		28,691	22
23	Other(specify): <u>Due from Affiliate,</u>	1,938,008	1,940,150	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,980,512	\$ 2,718,511	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,144,651	\$ 2,887,933	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 93,471	\$ 89,997	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,060	10,060	28
29	Short-Term Notes Payable		24,772	29
30	Accrued Salaries Payable	86,245	86,245	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,914	2,914	31
32	Accrued Real Estate Taxes(Sch.IX-B)		16,239	32
33	Accrued Interest Payable		2,276	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Exp/Ins,due to IDPA,Sales Tax</u>	24,413	24,413	36
37	<u>Due to Affiliates</u>	22,782	22,782	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 239,885	\$ 279,698	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,067,820	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,067,820	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 239,885	\$ 1,347,518	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,904,766	\$ 1,540,415	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,144,651	\$ 2,887,933	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,768,208	1
2	Restatements (describe):		2
3	Non-Allowable cost or revenue adjustments recorded after	38,327	3
4	prior year report submitted		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,806,535	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	98,231	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 98,231	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)	\$ 1,904,766	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town East

0042069

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,273,186	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,273,186	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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	See PG19A	285,163	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 285,163	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,558,349	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	225,804	31
32	Health Care	461,817	32
33	General Administration	290,793	33
B. Capital Expense			
34	Ownership	110,031	34
C. Ancillary Expense			
35	Special Cost Centers	296,305	35
36	Provider Participation Fee	75,368	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,460,118	40
41	Income before Income Taxes (line 30 minus line 40)**	98,231	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 98,231	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,095,438	44
45	Private Pay - Net Inpatient Revenue	177,748	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)	\$ 1,273,186	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 of Old Town East

0042069

Report Period Beginning 01/01/2017 Ending:

12/31/2017

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc. Income GL#4977 (discribe) (is offset against Sch.# V)	
Day Training Income	\$ 284,721
Record Copies-Backed out with Ln ref 21-Pg 5A	
Jury Duty-Backed out with Ln ref 22-Pg 5A	
Write Off Old Accounts Payables	
Vendor Discount	
United Healthcare-(Rebate/Incentive)	
U'SAgain LLc	
Gain on Sale of Assets (related to prior yr, not offset on Sch.# V)	\$ 442
Line 28 Total:	<u>285,163</u>

Facility Name & ID Number Alden of Old Town East

0042069

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	483	15,270	28.33	3
4	Licensed Practical Nurses	2,466	94,292	35.68	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	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	3,937	61,156	14.04	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	2,396	33,725	12.44	18
19	Laundry				19
20	Administrator	468	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)	21,442	299,862	12.79	30
31	Medical Records				31
32	Other Health C: Behavioral Special	321	10,308	30.59	32
33	Other(specify) Facility Manager	1,040	26,780	25.75	33
34	TOTAL (lines 1 - 33)	33,050	\$ 569,681 *	\$ 15.81	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	325/Month	\$ 3,900	1-3	35
36	Medical Director	300/Month	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	32/Month	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	220	11-3	44
45	Social Service Consultant	8	560	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	12	\$ 8,664		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

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Nancy Rodriguez	Administrator	0	\$ 17,694	Workers' Compensation Insurance	\$ 14,678	IDPH License Fee	\$		
				Unemployment Compensation Insurance	4,919	Advertising: Employee Recruitment	85		
				FICA Taxes	40,081	Health Care Worker Background Check (Indicate # of checks performed)	0		
				Employee Health Insurance	35,207	Patient Background Checks	0		
				Employee Meals	4,328	Surety Bond Fees	188		
				Illinois Municipal Retirement Fund (IMRF)*		Corporate Annual Fees	154		
				Dental and Life Insurance	396	Health Care Council of Illinois	1,536		
				Employee Relations/Misc. Payroll/Drug Tests	3,429	Collaborative Healthcare/Center for Developm	1,178		
				Vaccinations/401K Match/Tuition Reimbursement	642	Related Party - AMS	145		
				Related Party -Forum Pharmacy	(336)	Less: Public Relations Expense (
						Non-allowable advertising (
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 17,694	TOTAL (agree to Schedule V, line 22, col.8)		\$ 103,344	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,286
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Related Party - AMS	137	
C. Professional Services									
Vendor/Payee	Type		Amount						
Alden Management Services, Inc.	consulting fee		\$ 67,317				Seminar Expense		
Alden Group (Midcap Charges)	Legal Fees - Non Collections		220				Psychological Assessments	42	
Simandl Law Group	Legal Fees - Non Collections		61				Reasoning with Unreasonable	19	
AMS (eliminated)	Allocated Legal Fees		24,000				Entertainment Expense (
BDO Seidman	Accounting Fees		1,315				(agree to Sch. V, line 24, col. 8)		
Alden Group (Midcap Charges)	Accounting Fees		192				TOTAL	\$ 198	
Baker Tilly	Accounting Fees		2,710						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 95,815	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Alden of Old Town East
 Legal Fee Support
 2017

Legal Fees Reported on Pg 21, Section C: \$ 24,281.00

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 \$ 281.00

In Detail:

Vendor Name	Invoice Date	Amount
Alden Group (Midcap Charges)	17,2/17,5/17,8/17,9/17,10/1	220.00
Simandl Law Group	1/17	61.00
TOTAL ALLOWABLE LEGAL FEES		<u>281.00</u>

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

Vendor Name	Invoice Date	Amount
AMS Allocated Legal Fees	Monthly	24,000.00

TOTAL Allocated Legal Fees 24,000.00

Total Legal Cost 24,281.00

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? REH:Yes;RN/LPN:No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council 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. \$ 6,519 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. \$ 75,368
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. \$ 4,328 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