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: 0042077

Facility Name: Alden of Old Town West

Address: 118 S Bloomingdle Rd (Number) | Bloomingdale (City) | 60108 (Zip Code)

County: Dupage

Telephone Number: (630) 671-1660 **Fax #** (630) 671-0457

HFS ID Number:

Date of Initial License for Current Owners: 05/19/98

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 01/01/2017 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) _____ (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 of Old Town West # 0042077 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 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	5,840	6
7	16	TOTALS	16	5,840	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	5,730			5,730	13
14	TOTALS	5,730			5,730	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.12%

D. How many bed reserve days during this year were paid by the Department?
20 (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 [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 05/19/98

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

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

Facility Name & ID Number Alden of Old Town West # 0042077 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	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	66,214	2,972	3,869	73,055	56	73,111	(1,096)	72,015			1
2	Food Purchase		42,251		42,251	(7,395)	34,856	471	35,327			2
3	Housekeeping	9,473	5,616		15,089		15,089	947	16,036			3
4	Laundry		4,482		4,482		4,482		4,482			4
5	Heat and Other Utilities			22,840	22,840		22,840	(69)	22,771			5
6	Maintenance			50,046	50,046	1,784	51,830	10,234	62,064			6
7	Other (specify):* related party/security			300	300		300	1,061	1,361			7
8	TOTAL General Services	75,687	55,321	77,055	208,063	(5,555)	202,508	11,548	214,056			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	494,672	22,814	1,563	519,049	375	519,424	6,938	526,362			10
10a	Therapy			6,566	6,566		6,566	964	7,530			10a
11	Activities	20,902	55	647	21,604		21,604		21,604			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* related party							1,027	1,027			15
16	TOTAL Health Care and Programs	515,574	22,869	12,376	550,819	375	551,194	8,929	560,123			16
	C. General Administration											
17	Administrative	17,695			17,695		17,695	20,284	37,979			17
18	Directors Fees											18
19	Professional Services			101,780	101,780		101,780	(74,184)	27,596			19
20	Dues, Fees, Subscriptions & Promotions			4,417	4,417		4,417	(1,073)	3,344			20
21	Clerical & General Office Expenses	26,781	799	25,676	53,256		53,256	26,491	79,747			21
22	Employee Benefits & Payroll Taxes			122,292	122,292	6,964	129,256	(323)	128,933			22
23	Inservice Training & Education											23
24	Travel and Seminar			142	142		142	138	280			24
25	Other Admin. Staff Transportation			379	379		379	1,513	1,892			25
26	Insurance-Prop.Liab.Malpractice			21,658	21,658		21,658	1,438	23,096			26
27	Other (specify):* related party			(500)	(500)		(500)	8,588	8,088			27
28	TOTAL General Administration	44,476	799	275,844	321,119	6,964	328,083	(17,128)	310,955			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	635,737	78,989	365,275	1,080,001	1,784	1,081,785	3,349	1,085,134			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 West #0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,728	2,728	(1,784)	944	37,992	38,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,511	11,511		11,511	29,947	41,458			32
33	Real Estate Taxes			17,925	17,925	(17,925)		17,720	17,720			33
34	Rent-Facility & Grounds			75,912	75,912	17,925	93,837	(93,837)				34
35	Rent-Equipment & Vehicles			760	760		760	4,130	4,890			35
36	Other (specify):* MIP							5,518	5,518			36
37	**TOTAL Ownership**			108,836	108,836	(1,784)	107,052	1,470	108,522			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,365		3,365		3,365	38	3,403			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,917	78,917		78,917		78,917			42
43	Other (specify):* Day Training			294,720	294,720		294,720		294,720			43
44	**TOTAL Special Cost Centers**		3,365	373,637	377,002		377,002	38	377,040			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	635,737	82,354	847,748	1,565,839		1,565,839	4,857	1,570,696			45

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

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

Reclassifications - Pages 3 & 4

From Line	To Line	Amount	Description	
2		(7,395)	Employee Meals	Entered
	22	7,395	Employee Meals	Entered
22		(431)	Uniform Reclass	Entered
	1	56	Uniform Reclass	Entered
	3		Uniform Reclass	Entered
	4		Uniform Reclass	Entered
	6		Uniform Reclass	Entered
	10	375	Uniform Reclass	Entered
	11		Uniform Reclass	Entered
	21		Uniform Reclass	Entered
10		None	Oxygen Cost Reclass	Entered
	39	None	Oxygen Cost Reclass	Entered
33		(17,925)	Rent - Real Estate Tax on associated landowner (Pg 6)	
	34	17,925	Rent - Real Estate Tax on associated landowner (Pg 6)	
30		(1,784)	Reclass Depreciation on Painting	
	6	1,784	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 West # 0042077 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.)

	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	(4,067)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,097)	21		17
18	Fines and Penalties	(505)	32		18
19	Entertainment				19
20	Contributions	(450)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	500	27		24
25	Fund Raising, Advertising and Promotional	(769)	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)**	$ (7,404)		$	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)	19,439	Pg 6s	34
35	Other- Attach Schedule	(7,178)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 12,261		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 4,857		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 of Old Town West

ID# 0042077

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utlities	$ (461)	5	1
2	Intercompany Interest	(10,728)	32	2
3				3
4	Elim Deprec Exp on Pg 12 items under $2,500 -	(1,071)	30	4
5	Elim Deprec Exp on Pg 13 items under $2500 -	(4,204)	30	5
6	Expense Pg 12 items under $2,500 - curr yr purchs +	1,115	6	6
7	Expense Pg 13 items under $2,500 - curr yr purchs +	9,809	6	7
8	Reconcile Depreciation expense	(1,655)	30	8
9	Elim ABC Deprec Exp from Pg 12 series -	17	30	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				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**	(7,178)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town West # 0042077 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 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	323	(1,419)	0	0	0	0	0	0	0	(1,096)	1
2	Food Purchase	0	0	0	471	0	0	0	0	0	0	0	471	2
3	Housekeeping	0	0	947	0	0	0	0	0	0	0	0	947	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(461)	0	392	0	0	0	0	0	0	0	0	(69)	5
6	Maintenance	6,857	0	3,367	0	0	0	(12)	22	0	0	0	10,234	6
7	Other (specify):*	0	0	1,061	0	0	0	0	0	0	0	0	1,061	7
8	**TOTAL General Services**	6,396	0	6,090	(948)	0	0	(12)	22	0	0	0	11,548	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	6,811	277	(150)	0	0	0	0	0	0	6,938	10
10a	Therapy	0	0	0	0	0	964	0	0	0	0	0	964	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	1,027	0	0	0	0	0	0	0	0	1,027	15
16	**TOTAL Health Care and Programs**	0	0	7,838	277	(150)	964	0	0	0	0	0	8,929	16
	C. General Administration													
17	Administrative	0	0	20,284	0	0	0	0	0	0	0	0	20,284	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9)	2,900	(77,075)	0	0	0	0	0	0	0	0	(74,184)	19
20	Fees, Subscriptions & Promotions	(1,219)	0	146	0	0	0	0	0	0	0	0	(1,073)	20
21	Clerical & General Office Expenses	(2,097)	102	28,486	0	0	0	0	0	0	0	0	26,491	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(323)	0	0	0	0	0	0	(323)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	138	0	0	0	0	0	0	0	0	138	24
25	Other Admin. Staff Transportation	0	0	1,513	0	0	0	0	0	0	0	0	1,513	25
26	Insurance-Prop.Liab.Malpractice	0	1,406	32	0	0	0	0	0	0	0	0	1,438	26
27	Other (specify):*	500	0	8,088	0	0	0	0	0	0	0	0	8,588	27
28	**TOTAL General Administration**	(2,825)	4,408	(18,388)	0	(323)	0	0	0	0	0	0	(17,128)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,571	4,408	(4,460)	(671)	(473)	964	(12)	22	0	0	0	3,349	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town West # 0042077 **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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,913)	42,123	2,782	0	0	0	0	0	0	0	0	37,992	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,240)	29,298	11,889	0	0	0	0	0	0	0	0	29,947	32
33	Real Estate Taxes	0	17,263	457	0	0	0	0	0	0	0	0	17,720	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	4,130	0	0	0	0	0	0	0	0	4,130	35
36	Other (specify):*	0	5,518	0	0	0	0	0	0	0	0	0	5,518	36
37	**TOTAL Ownership**	(18,153)	365	19,258	0	0	0	0	0	0	0	0	1,470	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	(125)	163	0	0	0	0	0	0	38	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	(125)	163	0	0	0	0	0	0	38	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,582)	4,773	14,798	(796)	(310)	964	(12)	22	0	0	0	4,857	45

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	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		17,263	17,263	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			$ 98,623	$ * 4,773	14

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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%	$ 392	$ 392	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		138	138	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,513	1,513	17
18	V	26	Insurance		Alden Management Services, Inc.		32	32	18
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		146	146	19
20	V	30	Depreciation		Alden Management Services, Inc.		2,782	2,782	20
21	V	33	Real Estate Taxes		Alden Management Services, Inc.		457	457	21
22	V	35	Rent- Equipment & Vehicles		Alden Management Services, Inc.		4,130	4,130	22
23	V	32	Interest		Alden Management Services, Inc.		11,889	11,889	23
24	V	1	Dietary		Alden Management Services, Inc.		323	323	24
25	V	3	Housekeeping		Alden Management Services, Inc.		947	947	25
26	V	7	Employee Benefits- Gen'l Services		Alden Management Services, Inc.		1,061	1,061	26
27	V	10	Nursing & Medical Record Salaries		Alden Management Services, Inc.		6,811	6,811	27
28	V	15	Employee Benefits- Health Care		Alden Management Services, Inc.		1,027	1,027	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		20,284	20,284	29
30	V	27	Employee Benefits- Admin		Alden Management Services, Inc.		8,088	8,088	30
31	V	19	Professional Fees	94,654	Alden Management Services, Inc.		17,579	(77,075)	31
32	V	21	General & Administrative	7,056	Alden Management Services, Inc.		35,542	28,486	32
33	V	6	Repairs & Maintenance	8,456	Alden Management Services, Inc.		11,823	3,367	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 110,166			$ 124,964	$ * 14,798	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Consultant	$ 3,600	Prism Health Care Sevices, Inc.	0.00%	$	$ (3,600)	15
16	V	1	Dietary Salary		Prism Health Care Sevices, Inc.		2,043	2,043	16
17	V	2	Tube Feeding		Prism Health Care Sevices, Inc.				17
18	V	10	Equipment Rental	360	Prism Health Care Sevices, Inc.		524	164	18
19	V	39	Supplies	1,615	Prism Health Care Sevices, Inc.		642	(973)	19
20	V	1	Gen'l & Admin & Benefit Costs		Prism Health Care Sevices, Inc.		138	138	20
21	V	2	Gen'l & Admin & Benefit Costs		Prism Health Care Sevices, Inc.		471	471	21
22	V	10	Gen'l & Admin & Benefit Costs		Prism Health Care Sevices, Inc.		113	113	22
23	V	39	Gen'l & Admin & Benefit Costs		Prism Health Care Sevices, Inc.		848	848	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			$ 5,575			$ 4,779	$ * (796)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 1,750	Forum Extended Care Services II, Inc.	0.00%	$ 1,615	$ (135)	15
16	V	39	I.V.		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care Products		Forum Extended Care Services II, Inc.				17
18	V	10	House Stock	1,552	Forum Extended Care Services II, Inc.		1,432	(120)	18
19	V	10	Pharm Consultant	384	Forum Extended Care Services II, Inc.		354	(30)	19
20	V	22	Employee Vaccinations	323	Forum Extended Care Services II, Inc.			(323)	20
21	V	39	Employee Vaccinations		Forum Extended Care Services II, Inc.		298	298	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			$ 4,009			$ 3,699	$ * (310)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 6,566	Community Physical Therapy & Associates, Ltd.	0.00%	$ 7,530	$ 964	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			$ 6,566			$ 7,530	$ * 964	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Repairs and Maintenance	$ 8,254	Alden Bennett Construction Company, Inc.	0.00%	$ 8,242	$ (12)	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			$ 8,254			$ 8,242	$ * (12)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Repairs and Maintenance	$ 99	Alden Design Group, Inc.	0.00%	$ 121	$ 22	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			$ 99			$ 121	$ * 22	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 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.	Bloomingdale	Alden Management Services, Inc.		Management	5
6			Alden Terrace of McHenry Rehabilitation and F	McHenry	Alden Gardens of Bloomingdale, 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 (	Bloomingdale	Alden Gardens of Waterford, LLC		Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingdale	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.	Bloomingdale	Fort Medical Equipment, LLC		Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, Inc.		Design & Engineerir	14
15			Alden Trails, Inc.	Bloomingdale				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.	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	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 West # 0042077 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	
	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	184,197	0.172	0.43	Salary	$ 803	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,566	0.172	0.43	Salary	434	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,566	0.172	0.43	Salary	434	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	114,398	0.172	0.43	Salary	499	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	184,197	0.129	0.43	Salary	803	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 Management Services, Inc.										12
13								TOTAL	$ 3,246		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 West # 0042077 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 [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	1,320,269	35	$ 90,340	$	5,730	$ 392	1
2	24	Trav & Seminar	Patient Days	1,320,269	35	31,744		5,730	138	2
3	25	Other Admin Travel	Patient Days	1,320,269	35	348,589		5,730	1,513	3
4	26	Insurance	Patient Days	1,320,269	35	7,373		5,730	32	4
5	20	Dues & Subscriptions	Patient Days	1,320,269	35	33,588		5,730	146	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		5,730	457	7
8	35	Rent-Equip & Vehicle	Patient Days	1,320,269	35	951,681		5,730	4,130	8
9	32	Interest	Patient Days/usage	1,320,269	35	2,187,612		5,730	11,889	9
10	1	Dietary Salary	Patient Days	1,320,269	35	74,426	74,426	5,730	323	10
11	3	Housekeeping Salary	Patient Days	1,320,269	35	218,203	218,203	5,730	947	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,320,269	35	244,557		5,730	1,061	12
13	10	Nurs & Med Records Salary	Patient Days	1,320,269	35	1,647,662	1,647,662	5,730	6,811	13
14	15	Employee Benefits -Health Care	Patient Days	1,320,269	35	236,654		5,730	1,027	14
15	17	Administrative Salary	Patient Days/usage	1,320,269	35	4,903,376	4,750,005	5,730	20,284	15
16	27	Employee Benefits - Admin	Patient Days	1,320,269	35	1,863,643		5,730	8,088	16
17	19	Professional fees	Patient Days	1,320,269	35	1,119,817	920,527	5,730	17,579	17
18	21	Gen'I & Admin	Patient Days	1,320,269	35	8,189,318	7,151,399	5,730	35,542	18
19	6	Repair & Maint.	Patient Days	1,320,269	35	1,823,498	1,358,004	5,730	11,823	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 24,221,106	$ 16,120,226		$ 124,964	25

Facility Name & ID Number Alden of Old Town West # 0042077 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** 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	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												3
4	Insurance Interest (GL 7053)		x	Medical Malpractice							278	4
5	Amortization of Fin Fees (GL 7105)		x	Refinancing							1,718	5
	Working Capital											
6	Related party-AMS		x	Working Capital							11,889	6
7												7
8												8
9	TOTAL Facility Related				$4,317.00		$ 1,212,967	$ 1,092,592			$ 41,478	9
	B. Non-Facility Related*											
10	Interest Income (GL 4975)		x								(7)	10
11	Int. Income R.R.		x								(13)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20)	14
15	TOTALS (line 9+line14)						$ 1,212,967	$ 1,092,592			$ 41,458	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.)**

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	$	17,342	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.)	$	17,039	2
3. Under or (over) accrual (line 2 minus line 1).	$	(303)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	17,566	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.	$	17,263	7
Plus: Related Party Taxes - See Pg RE_Tax	$	457	
Total Real Estate Tax Expense, Sch V, Line 33	$	17,720	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	16,407	8
	2013	17,099	9
	2014	17,337	10
	2015	16,847	11
	2016	17,039	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 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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 West COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042077

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached (Supplement)	Related party-Alden Management	$ 105,372.00	$ 457.00
2.	02-15-112-007	Nursing Home Facility	$ 17,039.00	$ 17,039.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 122,411.00	$ 17,496.00

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 West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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	18,000	1995	$ 150,868	1
2					2
3	TOTALS	18,000		$ 150,868	3

Facility Name & ID Number Alden of Old Town West # 0042077 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 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	16		1998	1998	$ 934,861	$ 23,372	40	$ 23,372	$	$ 433,001	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler system			1999	1,510		15			1,510	9
10	ABC-counter tops			2004	8,102		10			8,102	10
11	ABC-Installed Dining Room Flooring			2005	5,421	361	15	361		4,483	11
12	ABC-Kitchen Repairs			2005	6,146	410	15	410		5,124	12
13											13
14	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC			2011	11,117	556	20	556		3,753	14
15	Valve sprinkler/fire & replace ball valve - USFIRE			2011	4,190		5			4,190	15
16											16
17	USFIRE - Repair fire safety equipment			2012	4,785	479	10	479		2,674	17
18											18
19											19
20	Patio Walkway-raise and level-Alden Bennett			2014	2,742	183	15	183		564	20
21											21
22	Sprinkler, Fire Work - ALDBEN			2015	10,015	401	25	401		1,136	22
23											23
24	Replace Tile in Shower Room - ALDBEN			2016	5,242	134	39	134		179	24
25											25
26	Replace Tile in Shower Room - ALDBEN			2017	6,240	133	39	133		133	26
27	Replace Tile in Shower Room - ALDBEN			2017	8,905	171	39	171		171	27
28											28
29	Adj for ABC related party profit			2011	86	6		6		45	29
30	Adj for ABC related party profit			2014	(5)	(0)		(0)		(0)	30
31	Adj for ABC related party profit			2015	(19)	(2)		(2)		(5)	31
32	Adj for ABC related party profit			2016	(33)	(2)		(2)		(3)	32
33	Adj for ABC related party profit			2017	(12)	(1)		(1)		(1)	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 West # 0042077 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 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		$ 1,009,293	$ 26,201		$ 26,201	$	$ 465,056	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 sidwalks	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)		$ 1,088,247	$ 27,241		$ 27,241	$	$ 554,017	34

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 79,003	$ 10,883	$ 10,883	$		$ 59,368	71
72	Current Year Purchases	59,232	704	704			321	72
73	Fully Depreciated Assets	198,515	108	108			198,515	73
74								74
75	TOTALS	$ 336,750	$ 11,695	$ 11,695	$		$ 258,204	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	Bus Transfer from AMS	Bus	2001	$ 16,646	$	$	$	5	$ 16,646	76
77	related party-AMS	various	1998-2004	3,911					3,911	77
78										78
79										79
80	TOTALS			$ 20,557	$	$	$		$ 20,557	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)	$ 1,596,422	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,936	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,936	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)	$ 832,778	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 West # 0042077 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 [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 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

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: $ 937 Description: copy machine GL 6861 - $760 and equipment lease GL 6859 - $177
(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	$ 153.67	$ 1,844	17
18					18
19	Auto lease - gl 6890	various	0.00		19
20					20
21	TOTAL		$ 153.67	$ 1,844	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 of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

Facility Name & ID Number Alden of Old Town West

STATE OF ILLINOIS
0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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				1,913		1,913	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						1,490		1,490	13
14	TOTAL			$		$	$ 3,403		$ 3,403	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

XIV. Special Services (Direct Cost)

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.					
	Phamacy Supplies per GL			1,749.00	
	Manual Input from Related Party- Forum Drugs & Vaccinations			164.00	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	1,913.00	
10.					
11.					
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00	
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00	
	Total Exceptional Care (Line 12, Col 8)			0.00	
13.	Other:	See Pg 16A			
13.	Col 5: Manual Input: Related Party - CPT		To Col 5		From Page 6D
	Other			1,615.00	
	Manual Input: Related Party - Prism			(125.00)	From Page 6B
	Manual Input: Related Party FECII - I.V.			0.00	From Page 6C
	Manual Input: Related Party FECII - Wound Care Products			0.00	From Page 6C
	Oxygen, from reclass worksheet (Pg 4A)				
13.	Col 6: Supplies Total		To Col 6	1,490.00	
13.	Total Line 13, Column 8			1,490.00	
14.	Total			3,403.00	

Facility Name & ID Number Alden of Old Town West **#** 0042077 **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 Operating	2 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)	128,289	128,289	3
4	Supply Inventory (priced at)	690	690	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,283	6
7	Other Prepaid Expenses	1,510	1,510	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd party			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 130,489	$ 135,772	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		141,874	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	42,951	89,637	15
16	Equipment, at Historical Cost	60,955	282,600	16
17	Accumulated Depreciation (book methods)	(86,388)	(733,545)	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 Refinancing Fees		28,691	22
23	Other(specify): Due from Affiliate,	1,361,234	1,363,838	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,378,752	$ 2,118,174	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,509,241	$ 2,253,946	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,082	$ 122,608	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,773	1,773	28
29	Short-Term Notes Payable		24,772	29
30	Accrued Salaries Payable	91,624	91,624	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,044	3,044	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,560	32
33	Accrued Interest Payable		2,276	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp/Ins,due to IDPA,SalesTax	23,588	23,588	36
37	Due to Affiliates	16,972	16,972	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 263,083	$ 304,217	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)**	$ 263,083	$ 1,372,037	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,246,158	$ 881,909	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,509,241	$ 2,253,946	48

***(See instructions.)**

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,199,644	1
2	Restatements (describe):		2
3	**Non-allowable cost or revenue adjustments recorded**		3
4	**after prior year report submitted:**	(23,356)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,176,288	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	69,870	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)**	$ 69,870	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)**	$ 1,246,158	24 *

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

Facility Name & ID Number Alden of Old Town West # 0042077 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,339,832	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,339,832	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***	7	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See PG19A	295,870	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 295,870	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,635,709	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	208,063	31
32	Health Care	550,819	32
33	General Administration	321,119	33
	B. Capital Expense		
34	Ownership	108,836	34
	C. Ancillary Expense		
35	Special Cost Centers	298,085	35
36	Provider Participation Fee	78,917	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,565,839	40
41	**Income before Income Taxes (line 30 minus line 40)****	69,870	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 69,870	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,339,832	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)	$ 1,339,832	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 West** **#** **0042077** **Report Period Beginning** **01/01/2017** **Ending:** **12/31/2017**

Details of Page 19, Line 28

Description	Amount
Misc. Income GL#4977 (discribe) (is offset against Sch.# V)	
Day Training Income	$ 294,720
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)	$ 1,150
Line 28 Total:	295,870

Facility Name & ID Number Alden of Old Town West # 0042077 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 # 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	4,417	5,186	161,305	31.10	3
4	Licensed Practical Nurses	551	564	12,579	22.30	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	497	497	10,594	21.32	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,383	4,671	66,214	14.18	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	520	520	9,473	18.22	18
19	Laundry					19
20	Administrator	468	470	17,695	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)	1,801	1,977	33,013	16.70	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	20,244	21,556	287,775	13.35	30
31	Medical Records					31
32	Other Health C: Behavioral Special	321	337	10,308	30.59	32
33	Other(specify) Facility Manager	1,040	1,040	26,781	25.75	33
34	TOTAL (lines 1 - 33)	34,242	36,818	$ 635,737 *	$ 17.27	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	325/Month	$ 3,869	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	3	165	11-3	44
45	Social Service Consultant	6	420	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	$ 8,438		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 of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Rodriguez	Administrator	0	$ 17,695
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 17,695

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	$ 70,654
Alden Group (Midcap Charges)	Legal Fees - Non Collections	220
A Traub's Associates	Legal Fees - Non Collections	1,401
Ariana Fisch	Legal Fees - Non Collections	8
Simandl Law Group	Legal Fees - Non Collections	61
Alden Management Services, Inc.	Allocated Legal Fees	24,000
MPRO Administration Org.	Professional Fees	1,210
BDO Seidman	Accounting Fees	1,315
Alden Group (Midcap Charges)	Accounting Fees	192
Baker Tilly	Accounting Fees	2,710
Ariana Fisch	Legal Fees - Collections	9
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 101,780

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,527
Unemployment Compensation Insurance	11,073
FICA Taxes	50,269
Employee Health Insurance	38,659
Employee Meals	7,395
Illinois Municipal Retirement Fund (IMRF)*	
Dental and Life Insurance	742
Employee Relations/Misc Payroll/Drug Testing	1,397
Vaccinations/401K Match	1,194
Related Party -Forum Pharmacy	(323)
TOTAL (agree to Schedule V, line 22, col.8)	$ 128,933

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	85
Health Care Worker Background Check	
(Indicate # of checks performed 2)	
Patient Background Checks	20
Surety Bond Fees	225
Corporate Annual Fee	154
Health Care Council of Illinois	1,536
Colborative Healthcare/Center for Developme	1,178
Related Party - AMS	146
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,344

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party - AMS	138
Seminar Expense	
Psychological Assessments	42
Reasoning with Unreasonable	19
Institute of Natural Resources	81
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 280

**See instructions.

Alden of Old Town West
Legal Fee Support
2017

Legal Fees Reported on Pg 21, Section C:	$	25,699.00
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22		(9.00)
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	$	1,690.00

In Detail:

Vendor Name	Invoice Date	Amount
Alden Group (Midcap Charges)	17,2/17,5/17,8/17,9/17,10/1	220.00
A Traub's Associates	3/17	1,401.00
Ariana Fisch	12/17	8.00
Simandl Law Group	1/17	61.00
TOTAL ALLOWABLE LEGAL FEES		**1,690.00**

Vendor Name	Invoice Date	Amount
Ariana Fisch	1/17	9.00
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		**9.00**

Vendor Name	Invoice Date	Amount
AMS (Eliminated)		24,000.00
TOTAL Allocated Legal Fees		**24,000.00**
Total Legal Cost		**25,699.00**

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **HAB: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. $ **11,625** 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. $ **78,917**
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. $ **7,395** 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