

		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.

<p>I. IDPH License ID Number: <u>0049122</u></p> <p>Facility Name: <u>Alden Village North</u></p> <p>Address: <u>7464 N Sheridan Rd</u> <u>Chicago</u> <u>60626</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773)338-0200</u> Fax # <u>(773)338-5122</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/3/08</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Randi Schlossberg-Schullo</u> (Title) <u>President, Alden Management Services, Inc.</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Randi Schlossberg-Schullo</u> (Title) <u>President, Alden Management Services, Inc.</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Randi Schlossberg-Schullo</u> (Title) <u>President, Alden Management Services, Inc.</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Alden Village North

0049122 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	150	Skilled Pediatric (SNF/PED)	150	54,750	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less		0	6
7	150	TOTALS	150	54,750	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	36,607	99	10	36,716	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,607	99	10	36,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.06%

D. How many bed reserve days during this year were paid by the Department?
451 (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 1/3/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/3/08 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 Not Applicable

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 Village North # 0049122 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	300,808	15,512	26,760	343,080	8,144	351,224	4,386	355,610		1
2	Food Purchase		561,231		561,231	(28,553)	532,678	(211,140)	321,538		2
3	Housekeeping	216,946	41,197		258,143	7,241	265,384	6,068	271,452		3
4	Laundry	102,962	19,129		122,091		122,091		122,091		4
5	Heat and Other Utilities			197,780	197,780		197,780	(300)	197,480		5
6	Maintenance	49,145		205,832	254,977		254,977	32,793	287,771		6
7	Other (specify):* related party							6,801	6,801		7
8	TOTAL General Services	669,860	637,069	430,373	1,737,302	(13,168)	1,724,134	(161,392)	1,562,742		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,872,411	140,121	13,384	3,025,916	(18,554)	3,007,362	56,742	3,064,104		10
10a	Therapy			113,041	113,041		113,041	42,637	155,678		10a
11	Activities	168,813	6,911	10,263	185,987		185,987		185,987		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							6,581	6,581		15
16	TOTAL Health Care and Programs	3,041,224	147,032	142,687	3,330,944	(18,554)	3,312,390	105,960	3,418,349		16
	C. General Administration										
17	Administrative	174,000			174,000		174,000	129,972	303,972		17
18	Directors Fees										18
19	Professional Services			484,886	484,886		484,886	(401,554)	83,332		19
20	Dues, Fees, Subscriptions & Promotions			41,505	41,505		41,505	(12,878)	28,627		20
21	Clerical & General Office Expenses	155,124	10,206	93,712	259,042	1,351	260,393	184,539	444,932		21
22	Employee Benefits & Payroll Taxes			694,319	694,319	7,580	701,899	(1,792)	700,107		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,485	1,485		1,485	883	2,368		24
25	Other Admin. Staff Transportation			4,616	4,616		4,616	9,694	14,310		25
26	Insurance-Prop.Liab.Malpractice			241,107	241,107		241,107	7,329	248,436		26
27	Other (specify):* related party			33,051	33,051		33,051	18,776	51,827		27
28	TOTAL General Administration	329,123	10,206	1,594,680	1,934,010	8,931	1,942,941	(65,031)	1,877,910		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,040,208	794,307	2,167,740	7,002,255	(22,791)	6,979,464	(120,464)	6,859,001		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 Village North

#0049122

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			28,413	28,413		28,413	278,370	306,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,920	2,920		2,920	629,040	631,960			32
33	Real Estate Taxes			140,755	140,755	(140,755)		154,461	154,461			33
34	Rent-Facility & Grounds			998,460	998,460	140,755	1,139,215	(1,139,215)				34
35	Rent-Equipment & Vehicles			15,735	15,735		15,735	26,466	42,201			35
36	Other (specify):* MIP							68,596	68,596			36
37	TOTAL Ownership			1,186,284	1,186,284		1,186,284	17,718	1,204,002			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,866		229,866	22,791	252,657	(12,065)	240,592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			424,096	424,096		424,096		424,096			42
43	Other (specify):* DD Day Training			1,226,386	1,226,386		1,226,386		1,226,386			43
44	TOTAL Special Cost Centers		229,866	1,650,482	1,880,348	22,791	1,903,139	(12,065)	1,891,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,040,208	1,024,173	5,004,506	10,068,888		10,068,888	(114,810)	9,954,077			45

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

0049122
 Period Beginning: 01/01/2017
 Period Ending: 12/31/2017

IDPH License No. 0

Page 4A

Reclassifications - Pages 3 & 4

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(28,553)	Employee Meals
	22	28,553	Employee Meals
22		(20,973)	Uniform Reclass
	1	8,144	Uniform Reclass
	3	7,241	Uniform Reclass
	4	-	Uniform Reclass
	6	-	Uniform Reclass
	10	4,237	Uniform Reclass
	11	-	Uniform Reclass
	21	1,351	Uniform Reclass
10		(22,791)	Oxygen Cost Reclass
	39	22,791	Oxygen Cost Reclass
33		(140,755)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	140,755	Rent - Real Estate Tax on associated landowner (Pg 6)

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	(7,917)	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	(952)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(102)	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	(1,347)	21		17
18	Fines and Penalties	(312)	32		18
19	Entertainment	(1,630)	20		19
20	Contributions	(4,590)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(256)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,051)	27		24
25	Fund Raising, Advertising and Promotional	(7,592)	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)	\$ (57,749)		\$	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)	(71,554)	Pg 6s	34
35	Other- Attach Schedule	14,493	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (57,061)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (114,810)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Alden Village North

ID# 0049122

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (1,665)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(13,706)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	2,203	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	20,366	6	4
5	Elim ABC Deprec Exp from Pg 12 series -	(11)	30	5
6	Utility Late Fees	(2,812)	5	6
7	Misc Income-Jury Duty	(17)	21	7
8	Misc Income-Record Copies	(120)	10	8
9	Misc Income-Polling Site		21	9
10	Misc Income-Donations	(565)	21	10
11	Adj Depreciation to Pg 13's	220	30	11
12	Other nursing income	(96)	21	12
13	Back Out Real Estate Tax Bank Fee	(80)	21	13
14	AMS Depreciation Adj.		30	14
15	Back out R/E Tax Refund	10,776	33	15
16				16
17	Marketing Manager & Aides		21	17
18	Eliminate portion of market benefits		22	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	14,493		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village North

0049122

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	2,070	2,316	0	0	0	0	0	0	0	4,386	1
2	Food Purchase	(102)	0	0	(211,038)	0	0	0	0	0	0	0	(211,140)	2
3	Housekeeping	0	0	6,068	0	0	0	0	0	0	0	0	6,068	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,812)	0	2,512	0	0	0	0	0	0	0	0	(300)	5
6	Maintenance	14,652	0	17,862	0	0	0	(37)	317	0	0	0	32,793	6
7	Other (specify):*	0	0	6,801	0	0	0	0	0	0	0	0	6,801	7
8	TOTAL General Services	11,738	0	35,313	(208,723)	0	0	(37)	317	0	0	0	(161,392)	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	(120)	0	43,645	14,261	(1,045)	0	0	0	0	0	0	56,742	10
10a	Therapy	0	0	0	0	0	42,637	0	0	0	0	0	42,637	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	6,581	0	0	0	0	0	0	0	0	6,581	15
16	TOTAL Health Care and Programs	(120)	0	50,226	14,261	(1,045)	42,637	0	0	0	0	0	105,960	16
	C. General Administration													
17	Administrative	0	0	129,972	0	0	0	0	0	0	0	0	129,972	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(256)	11,029	(412,327)	0	0	0	0	0	0	0	0	(401,554)	19
20	Fees, Subscriptions & Promotions	(13,812)	0	934	0	0	0	0	0	0	0	0	(12,878)	20
21	Clerical & General Office Expenses	(2,105)	387	186,257	0	0	0	0	0	0	0	0	184,539	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(1,792)	0	0	0	0	0	0	(1,792)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	883	0	0	0	0	0	0	0	0	883	24
25	Other Admin. Staff Transportation	0	0	9,694	0	0	0	0	0	0	0	0	9,694	25
26	Insurance-Prop.Liab.Malpractice	0	7,124	205	0	0	0	0	0	0	0	0	7,329	26
27	Other (specify):*	(33,051)	0	51,827	0	0	0	0	0	0	0	0	18,776	27
28	TOTAL General Administration	(49,224)	18,540	(32,555)	0	(1,792)	0	0	0	0	0	0	(65,031)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,606)	18,540	52,984	(194,461)	(2,837)	42,637	(37)	317	0	0	0	(120,464)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Village North

0049122

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	(15,162)	290,750	2,782	0	0	0	0	0	0	0	0	278,370	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,264)	622,862	7,442	0	0	0	0	0	0	0	0	629,040	32
33	Real Estate Taxes	10,776	140,755	2,930	0	0	0	0	0	0	0	0	154,461	33
34	Rent-Facility & Grounds	0	(1,139,215)	0	0	0	0	0	0	0	0	0	(1,139,215)	34
35	Rent-Equipment & Vehicles	0	0	26,466	0	0	0	0	0	0	0	0	26,466	35
36	Other (specify):*	0	68,596	0	0	0	0	0	0	0	0	0	68,596	36
37	TOTAL Ownership	(5,650)	(16,252)	39,620	0	0	0	0	0	0	0	0	17,718	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	(6,652)	(5,412)	0	0	0	0	0	0	(12,065)	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	(6,652)	(5,412)	0	0	0	0	0	0	(12,065)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(43,256)	2,288	92,604	(201,113)	(8,249)	42,637	(37)	317	0	0	0	(114,810)	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 Rent Income	\$ 1,139,215	Alden Village North II, LLC	0.00%	\$	\$ (1,139,215)	1
2	V	32 Interest Income Repl Reserve	234	Alden Village North II, LLC			(234)	2
3	V	32 Interest Income		Alden Village North II, LLC				3
4	V	6 Repairs & Maintenance		Alden Village North II, LLC				4
5	V	19 Acct Fees/Legal Fees: Non-coll		Alden Village North II, LLC		11,029	11,029	5
6	V	21 Misc Administrative Expenses		Alden Village North II, LLC		387	387	6
7	V	19 Professional Fees		Alden Village North II, LLC				7
8	V	33 Real Estate Tax Expense		Alden Village North II, LLC		140,755	140,755	8
9	V	26 General Insurance Expense		Alden Village North II, LLC		7,124	7,124	9
10	V	36 Mortgage Insurance Premium		Alden Village North II, LLC		68,596	68,596	10
11	V	32 Interest- Mortgage		Alden Village North II, LLC		617,396	617,396	11
12	V	30 Depreciation Expense		Alden Village North II, LLC		290,750	290,750	12
13	V	32 Amortization Expense		Alden Village North II, LLC		5,700	5,700	13
14	Total		\$ 1,139,449			\$ 1,141,737	\$ * 2,288	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 2,512	\$	2,512	15
16	V	24 Trav & Seminar		Alden Management Services, Inc.		883		883	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		9,694		9,694	17
18	V	26 Insurance		Alden Management Services, Inc.		205		205	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		934		934	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,782		2,782	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		2,930		2,930	21
22	V	35 Rent -Equip & Vehicles		Alden Management Services, Inc.		26,466		26,466	22
23	V	32 Interest		Alden Management Services, Inc.		7,442		7,442	23
24	V	1 Dietary		Alden Management Services, Inc.		2,070		2,070	24
25	V	3 Housekeeping		Alden Management Services, Inc.		6,068		6,068	25
26	V	7 Employee Benefits -Gen'L Servs		Alden Management Services, Inc.		6,801		6,801	26
27	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		43,645		43,645	27
28	V	15 Employee Benefits -Health Care		Alden Management Services, Inc.		6,581		6,581	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		129,972		129,972	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		51,827		51,827	30
31	V	19 Professional Fees	449,342	Alden Management Services, Inc.		37,015		(412,327)	31
32	V	21 Gen'l & Admin	41,484	Alden Management Services, Inc.		227,741		186,257	32
33	V	6 Repair & Maint.	34,233	Alden Management Services, Inc.		52,095		17,862	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 525,059			\$ 617,663	\$ *	92,604	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	\$ 26,400	Prism Health Care Services, Inc.	0.00%	\$	\$ (26,400)
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		14,981	14,981
17	V	2 Tube Feeding	384,790	Prism Health Care Services, Inc.		126,785	(258,005)
18	V	10 Equipment Rental	6,660	Prism Health Care Services, Inc.		9,694	3,034
19	V	39 Ancillary Supplies	138,018	Prism Health Care Services, Inc.		46,254	(91,764)
20	V	39 Ventilator Rental		Prism Health Care Services, Inc.		586	586
21	V	1 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		13,734	13,734
22	V	2 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		46,967	46,967
23	V	10 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		11,228	11,228
24	V	39 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		84,526	84,526
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		\$ 555,868			\$ 354,755	\$ * (201,113)

* 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	\$ 62,854	Forum Extended Care Services II, Inc.	0.00%	\$ 58,018	\$ (4,836)
16	V	39 I.V.		Forum Extended Care Services II, Inc.			
17	V	39 Wound Care Products	28,994	Forum Extended Care Services II, Inc.		26,763	(2,231)
18	V	10 House Stock	9,979	Forum Extended Care Services II, Inc.		9,211	(768)
19	V	10 Pharm Consult.	3,600	Forum Extended Care Services II, Inc.		3,323	(277)
20	V	22 Employ. Vaccin.	1,792	Forum Extended Care Services II, Inc.			(1,792)
21	V	39 Employ. Vaccin.		Forum Extended Care Services II, Inc.		1,654	1,654
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		\$ 107,219			\$ 98,970	\$ * (8,249)

* 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	\$ 113,041	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 155,678	\$	42,637	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		\$ 113,041			\$ 155,678	\$ *	42,637	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 & Maintenance	\$ 27,896	Alden Bennett Construction Company, Inc.	0.00%	\$ 27,859	\$	(37)	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		\$ 27,896			\$ 27,859	\$ *	(37)	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 & Maintenance	\$ 1,446	Alden Design Group, Inc.	0.00%	\$ 1,763	\$ 317	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		\$ 1,446			\$ 1,763	\$ *	317	39

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

Facility Name & ID Number

Alden Village North

0049122

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 Village North # 0049122 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg A.	Chairman-Board of D	Chairman	100.00	179,855	1.112	2.78	Salary	\$ 5,145	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	97,219	1.112	2.78	Salary	2,781	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	97,219	1.112	2.78	Salary	2,781	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	111,702	1.112	2.78	Salary	3,195	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	61,207	1.112	2.78	Salary	1,751	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	179,855	0.834	2.78	Salary	5,145	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	\$ 20,798		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 Village North

0049122

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	35	\$ 90,340	\$	36,716	\$ 2,512	1
2	24	Trav & Seminar	Patient Days	35	31,744		36,716	883	2
3	25	Other Admin Travel	Patient Days	35	348,589		36,716	9,694	3
4	26	Insurance	Patient Days	35	7,373		36,716	205	4
5	20	Dues & Subscriptions	Patient Days	35	33,588		36,716	934	5
6	30	Depreciation	No of Providers/usage	35	119,326		1	2,782	6
7	33	Real Estate Tax	Patient Days/usage	35	129,699		36,716	2,930	7
8	35	Rent-Equip & Vehicle	Patient Days	35	951,681		36,716	26,466	8
9	32	Interest	Patient Days/usage	35	2,187,612		36,716	7,442	9
10	1	Dietary Salary	Patient Days	35	74,426	74,426	36,716	2,070	10
11	3	Housekeeping Salary	Patient Days	35	218,203	218,203	36,716	6,068	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	35	244,557		36,716	6,801	12
13	10	Nurs & Med Records Salary	Patient Days	35	1,647,662	1,647,662	36,716	43,645	13
14	15	Employee Benefits -Health Care	Patient Days	35	236,654		36,716	6,581	14
15	17	Administrative Salary	Patient Days/usage	35	4,903,376	4,750,005	36,716	129,972	15
16	27	Employee Benefits - Admin	Patient Days	35	1,863,643		36,716	51,827	16
17	19	Professional fees	Patient Days	35	1,119,817	920,527	36,716	37,015	17
18	21	Gen'I & Admin	Patient Days	35	8,189,318	7,151,399	36,716	227,741	18
19	6	Repair & Maint.	Patient Days	35	1,823,498	1,358,004	36,716	52,095	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 24,221,106	\$ 16,120,226		\$ 617,663	25

Facility Name & ID Number

Alden Village North

0049122

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	Cambridge Realty Capital, Ltd.		x	Mortgage	\$63,213.43	8/29/13	\$ 12,960,000	\$ 12,407,644	7/1/2051	4.9500	\$ 617,396	1
2												2
3												3
4	Insurance Interest (GL07053)		x	Medical Malpractice							2,608	4
5	Amort of Fin Fees (GL 1918)		x	Refinancing							5,700	5
Working Capital												
6	Related party-AMS		x								7,442	6
7												7
8												8
9	TOTAL Facility Related				\$63,213.43		\$ 12,960,000	\$ 12,407,644			\$ 633,146	9
B. Non-Facility Related*												
10	Interest Income on R.R.		x								(234)	10
11	Int Income (GL#4975)		x								(952)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,186)	14
15	TOTALS (line 9+line14)						\$ 12,960,000	\$ 12,407,644			\$ 631,960	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 68,596 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.			\$	131,300	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.)			\$	139,331	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	8,031	3
4.	Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	143,500	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.			\$	151,531	7
Real Estate Tax History:		Plus: Related Party Taxes - See Pg RE_Tax		\$	2,930	
		Total Real Estate Tax Expense, Sch V, Line 33		\$	154,461	
Real Estate Tax Bill for Calendar Year:	2012	121,451	8	FOR BHF USE ONLY		
	2013	123,095	9	13	FROM R. E. TAX STATEMENT FOR 2016	13
	2014	125,575	10	14	PLUS APPEAL COST FROM LINE 5	14
	2015	127,475	11	15	LESS REFUND FROM LINE 6	15
	2016	139,331	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 Village North COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049122

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773)286-3883 FAX #: (773)286-8038

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>See attached (Supplement)</u>	<u>Related party-Alden Management</u>	\$ <u>105,372.00</u>	\$ <u>2,930.00</u>
2. <u>11-29-307-019-0000</u>	<u>Nursing facility</u>	\$ <u>31,919.57</u>	\$ <u>31,919.57</u>
3. <u>11-29-307-020-0000</u>	<u>Nursing facility</u>	\$ <u>30,782.73</u>	\$ <u>30,782.73</u>
4. <u>11-29-307-022-0000</u>	<u>Nursing facility</u>	\$ <u>76,628.41</u>	\$ <u>76,628.41</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>244,702.71</u></u>	\$ <u><u>142,260.71</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 Village North

0049122

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,814 B. General Construction Type: Exterior Load Bearing CMU, B Frame Steel stud Number of Stories 3+Basement

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

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

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

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

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

none

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>nursing facility</u>	<u>33,315</u>	<u>2008</u>	<u>\$ 358,296</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	33,315		\$ 358,296	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	150	2008	1968	\$ 2,984,341	\$ 76,522	39	\$ 76,522	\$	\$ 765,220	4
5	Constuction Project HUD 2009-2011		2011	6,830,905	175,151	39	175,151		1,182,270	5
6										6
7										7
8	Related Party-Forum		1978	13,669		25			13,669	8
	Improvement Type**									
9	ABC-Doors		2008	5,996	600	10	600		5,949	9
10	ABC-Doors		2008	3,091	309	10	309		3,039	10
11	A&B Cable-Cable lines		2008	4,230	423	10	423		4,160	11
12	ABC-Remodel - plumbing		2008	4,635		5			4,635	12
13	ABC-Door entry system		2008	2,850	285	10	285		2,660	13
14	ABC-Hvac- major repair to system		2008	4,583		5			4,583	14
15	Capps-Drains - major repairs		2008	3,875		5			3,875	15
16	Renovate-gen'l labor AMS		2008	10,664		5			10,664	16
17	Renovate-gen'l labor AMS		2008	11,352		5			11,352	17
18	Capps-Repipe shower lines		2008	4,585		5			4,585	18
19	ABCPlumbing - major repair		2008	4,885		5			4,885	19
20	Wire building for cable		2009	6,518	652	10	652		5,813	20
21	Wire building for cable		2009	6,240	624	10	624		5,564	21
22	Wire building for cable		2009	2,800	280	10	280		2,403	22
23	ABCPlumbing - major repair		2009	17,539	877	20	877		7,820	23
24	ABC-Replace elevator shaft		2009	9,794	490	20	490		4,328	24
25	ABC-Replace elevator shaft		2009	39,178	1,959	20	1,959		17,304	25
26	Central States-Replace sprinkler alarm panel		2009	2,650		5			2,650	26
27	Patten-Major generator repair		2009	2,992		5			2,992	27
28	Patten-Major generator repair		2009	10,604		5			10,604	28
29	Fire sprinkler repair & corrections Focus Fire		2010	2,672		5			2,672	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ABC Job 1058-Phone lines new thruout	2011	\$ 9,348	\$ 623	15	\$ 623		\$ 4,013	37
38	ABC Job 1058-Carpet labor-children's exit	2011	2,000	133	15	133		857	38
39	ABC Job 1058-Ceramic flooring in kitchen	2011	1,369	91	15	91		586	39
40	ABC Job 1058-Structural Steel-exterior railings	2011	7,501	500	15	500		3,221	40
41	ABC Job 1058-Plumbing-kitchen sink and cleanout covers	2011	4,546	303	15	303		1,952	41
42	ABC Job 1058-concrete coring	2011	327	22	15	22		142	42
43	ABC Job 1058-Parking Lot-paving	2011	7,144	476	15	476		3,066	43
44	ABC Job 1058-Kitchen equipment	2011	3,542	236	15	236		1,520	44
45	ABC Job 1058-Finish Hardware-door kickplates, handles	2011	900	60	15	60		387	45
46	ABC Job 1058-Elevator-stainless steel cladding	2011	14,550	970	15	970		6,249	46
47	ABC Job 1058-Millwork cabinets-nurses station / work areas	2011	1,728	115	15	115		741	47
48	ABC Job 1058-Countertops-nurses station / work areas	2011	1,344	90	15	90		580	48
49	ABC Job 1058-Drywall-lower level	2011	3,398	227	15	227		1,462	49
50	ABC Job 1058-Smoke detectors-lower level	2011	3,365	224	15	224		1,443	50
51									51
52	Railing Ramp (2)-ALDBEN	2013	3,295	220	15	220		1,008	52
53	Hot water heater-J&EPLU	2013	3,168	634	5	634		3,117	53
54	Freezer, non-HVAC-TOPNOT	2013	3,049	610	5	610		2,592	54
55									55
56	Masonry and concrete work - FOXBUI	2014	4,200	840	5	840		2,800	56
57	Masonry, brick/tuckpointing (building)-ALDBEN	2015	18,703	748	25	748		1,496	57
58	Van A/C condensor module-AugAMS-WRIEXP-T&M Amoco	2015	3,088	772	4	772		1,673	58
59									59
60	Microbial Growth Remediation -DEDRES	2017	10,165	3,388	3	3,388		3,388	60
61	Duct & Pipe Insulation for HVAC - ALDBEN	2017	34,234	2,853	10	2,853		2,853	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,131,612	\$ 272,307		\$ 272,307		\$ 2,128,842	70

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

Facility Name & ID Number Alden Village North

0049122

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		\$ 10,131,612	\$ 272,307		\$ 272,307	\$	\$ 2,128,842	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)		\$ 10,210,566	\$ 273,347		\$ 273,347	\$	\$ 2,217,803	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		\$ 10,210,566	\$ 273,347		\$ 273,347	\$	\$ 2,217,803	1
2	Adj for ABC Related Party Profit	2008	(173)					(173)	2
3	Adj for ABC Related Party Profit	2009	(878)	(38)		(38)		(342)	3
4	Adj for ABC Related Party Profit-None	2010							4
5	Adj for ABC Related Party Profit	2011	475	28		28		182	5
6	Adj for ABC Related Party Profit	2013	44	4		4		18	6
7	Adj for ABC Related Party Profit	2014							7
8	Adj for ABC Related Party Profit	2015	(35)	(1)		(1)		(3)	8
9	Adj for ABC Related Party Profit	2017	(46)	(4)		(4)		(4)	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)		\$ 10,209,953	\$ 273,336		\$ 273,336	\$	\$ 2,217,481	34

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

Facility Name & ID Number Alden Village North

0049122

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	\$ 256,837	\$ 28,259	\$ 28,259	\$		\$ 148,021	71
72	Current Year Purchases	115,932	4,722	4,722			3,251	72
73	Fully Depreciated Assets	1,298,451	467	467			1,298,451	73
74								74
75	TOTALS	\$ 1,671,220	\$ 33,448	\$ 33,448	\$		\$ 1,449,722	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	related party-AMS	various	1998-2004	3,911				3	3,911	77
78										78
79										79
80	TOTALS			\$ 3,911	\$	\$	\$		\$ 3,911	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,243,380	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,783	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 306,783	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)	\$ 3,671,114	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 Village North

0049122

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 1/2/08

Ending 12/31/21

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2018</u>	\$ <u>1,150,014</u>
13.	<u>12/31/2019</u>	\$ <u>1,150,014</u>
14.	<u>12/31/2020</u>	\$ <u>1,150,014</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 13,884 Description: Copy Machine \$9,482.44 and Equipment Lease \$4,401.86

(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>984.75</u>	\$ <u>11,817</u>	17
18					18
19	<u>Auto lease - gl 6890</u>	<u>various</u>	<u>521.08</u>	<u>6,253</u>	19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>18,070</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				59,672		59,672	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					180,920		180,920	13
14	TOTAL			\$		\$	240,592		\$ 240,592	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		
2.	ST	39-3	To Col 5		
3.					
4.	PT	39-3	To Col 5		
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			62,854.09	
	Manual Input from Related Party- Forum Drugs & Vaccinations			(3,181.71)	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	59,672.38	
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	0.00	From Page 6D
	Other			167,011.81	
	Manual Input: Related Party - Prism			(6,652.27)	From Page 6B
	Manual Input: Related Party FECII - I.V.			0.00	From Page 6C
	Manual Input: Related Party FECII - Wound Care Products			(2,230.73)	From Page 6C
	Oxygen, from reclass worksheet (Pg 4A)			22,791.00	
13.	Col 6: Supplies Total		To Col 6	180,919.82	
13.	Total Line 13, Column 8			180,919.82	
14.	Total			240,592.20	

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	\$	\$ 25,043	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,000))	1,213,754	1,213,754	3
4	Supply Inventory (priced at)	1,749	1,749	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,728	194,852	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)	\$ 1,237,231	\$ 1,435,397	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		358,296	13
14	Buildings, at Historical Cost		9,815,246	14
15	Leasehold Improvements, at Historical Cost	314,520	447,755	15
16	Equipment, at Historical Cost	230,754	1,675,297	16
17	Accumulated Depreciation (book methods)	(458,168)	(3,702,256)	17
18	Deferred Charges	94,600	215,125	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		315,355	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Due from Affiliate</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 181,706	\$ 9,124,817	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,418,937	\$ 10,560,215	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 675,701	\$ 675,701	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,304	11,304	28
29	Short-Term Notes Payable		147,704	29
30	Accrued Salaries Payable	506,387	506,387	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,078	22,078	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,500	32
33	Accrued Interest Payable		51,182	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Ins, Exp, IDPA, Sales Tax, etc.</u>	161,943	161,943	36
37	<u>Due to Affiliates</u>	1,198,491	1,198,491	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,575,904	\$ 2,918,289	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,259,940	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliate</u>	14,063,793	13,962,216	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 14,063,793	\$ 26,222,156	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,639,697	\$ 29,140,445	46
47	TOTAL EQUITY(page 18, line 24)	\$ (15,220,760)	\$ (18,580,230)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,418,937	\$ 10,560,215	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,092,378)	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded	25,091	3
4	after prior year report submitted:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,067,287)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,153,473)	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)	\$ (1,153,473)	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)	\$ (15,220,760)	24 *

* This must agree with page 17, line 47.

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

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

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,659,411	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,659,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	23,832	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 23,832	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	96	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 96	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	952	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 952	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19A	1,231,124	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,231,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,915,415	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,737,302	31
32	Health Care	3,330,944	32
33	General Administration	1,934,010	33
B. Capital Expense			
34	Ownership	1,186,284	34
C. Ancillary Expense			
35	Special Cost Centers	1,456,252	35
36	Provider Participation Fee	424,096	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,068,888	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,153,473)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,153,473)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,629,116	44
45	Private Pay - Net Inpatient Revenue	28,325	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	1,969	47
48	Other-(specify) <u>Charity/Sales Allow.</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,659,411	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 Village North# 0049122Report 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 (describe) (is offset against Sch.# V)	
Misc Income-Jury Duty	\$ 17
Misc Income-Record Copies	\$ 120
Misc Income-Polling Site	
Misc Income-Donations	\$ 565
Day Training Income (not offset, actual costs reported)	\$ 1,226,386
Adj. to Prior Year Activity	
Gain on sale of asset	\$ 4,035
Line 28 Total:	<u>1,231,124</u>

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,241	2,241	\$ 96,584	\$ 43.10	1
2	Assistant Director of Nursing	1,974	2,186	75,025	34.32	2
3	Registered Nurses	15,209	15,870	602,927	37.99	3
4	Licensed Practical Nurses	22,629	23,697	604,594	25.51	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	52,993	25.48	9
10	Activity Assistants	8,143	8,679	105,513	12.16	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	47,724	22.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,594	20,593	253,084	12.29	15
16	Dishwashers					16
17	Maintenance Workers	1,880	1,981	49,145	24.81	17
18	Housekeepers	16,192	17,404	216,946	12.47	18
19	Laundry	7,601	8,392	102,962	12.27	19
20	Administrator	2,056	2,080	121,347	58.34	20
21	Assistant Administrator	2,080	2,080	52,653	25.31	21
22	Other Administrative	880	880	13,351	15.17	22
23	Office Manager					23
24	Clerical	5,341	5,715	90,217	15.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,472	7,510	118,404	15.77	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	92,706	99,507	1,319,492	13.26	30
31	Medical Records					31
32	Other Health C: Unit Manager/Beh	2,640	2,968	65,693	22.13	32
33	Other(specify) Resident Service D	2,080	2,291	51,555	22.50	33
34	TOTAL (lines 1 - 33)	213,878	228,231	\$ 4,040,208 *	\$ 17.70	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	2230/month	\$ 26,760	1-3	35
36	Medical Director	500/month	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	300/month	3,600	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,360		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

Alden Village North
 Legal Fee Support
 2017

Legal Fees Reported on Pg 21, Section C:	\$ 53,314.80
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22	(256.00)
Non-allowable legal fees, if any, deducted on - Pg 6A (AMS Allocated Legal Fees) + Add Back voided invoice of prior year, if any	(45,192.00)
Allowable Legal Fees	<u>\$ 7,866.80</u>

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
IIT Chicago-Kent College of Law	1/1/17- 12/31/17	2,789.07
Sheriff of Cook County	3/16/2017	120.00
Clerk Of The Circuit Court	3/16/2017	336.00
Von Briesen & Roper S.C	5/24/2017-10/31/2017	848.58
Peter J Latz	6/6/2017	1,182.50
Peck Ritchey, LLC	09/06/17	2,296.60
Ariana Fisch	11/22/2017	294.05
TOTAL ALLOWABLE LEGAL FEES		<u><u>7,866.80</u></u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
Markley Investigations	7/7/2017-8/27/2017	256.00
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		<u><u>256.00</u></u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
AMS Allocated Legal Fees	1/1/17- 12/31/17	45,192.00
TOTAL Allocated Legal Fees		<u><u>45,192.00</u></u>
Total Legal Cost		<u><u>53,314.80</u></u>

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? 'RN/LPN=No; HabAide' (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of Illinois \$14,400
- (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. \$ 33,914 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. \$ 424,096
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 28,553 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