

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0047191 Facility Name: Alden Springs Address: 207 East Army Trail Road Bloomingdale 60108 County: Dupage Telephone Number: (630) 523-5783 Fax #: (630) 523-5787 HFS ID Number: Date of Initial License for Current Owners: 9/25/06 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership X Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County 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 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Joan Carl (Title) Vice-President Paid Preparer (Signed) (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
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Facility Name & ID Number Alden Springs# 0047191 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,599			5,599	13
14	TOTALS	5,599			5,599	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.61%

D. How many bed-hold days during this year were paid by the Department?

126 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/13/06

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	56,572	5,187	1,200	62,959	909	63,868	65	63,933		1
2	Food Purchase		52,509		52,509	(3,757)	48,752	(5,409)	43,343		2
3	Housekeeping	12,062	7,183		19,245		19,245	631	19,876		3
4	Laundry		4,857		4,857		4,857		4,857		4
5	Heat and Other Utilities			21,409	21,409		21,409	219	21,628		5
6	Maintenance	11,885		39,542	51,427		51,427	3,104	54,531		6
7	Other (specify):* related party							914	914		7
8	TOTAL General Services	80,519	69,736	62,151	212,406	(2,848)	209,558	(476)	209,082		8
	B. Health Care and Programs										
9	Medical Director			3,550	3,550		3,550		3,550		9
10	Nursing and Medical Records	368,202	22,837	1,227	392,266	740	393,006	4,788	397,794		10
10a	Therapy		645		645	7,538	8,183	430	8,613		10a
11	Activities	9,806		22,744	32,550		32,550		32,550		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							657	657		15
16	TOTAL Health Care and Programs	378,008	23,482	27,521	429,011	8,278	437,289	5,875	443,164		16
	C. General Administration										
17	Administrative	16,350			16,350		16,350	12,263	28,613		17
18	Directors Fees										18
19	Professional Services			81,162	81,162		81,162	(73,328)	7,834		19
20	Dues, Fees, Subscriptions & Promotions			15,345	15,345		15,345	(13,066)	2,279		20
21	Clerical & General Office Expenses	45,839	1,586	10,083	57,508		57,508	31,575	89,083		21
22	Employee Benefits & Payroll Taxes			65,589	65,589	2,108	67,697		67,697		22
23	Inservice Training & Education										23
24	Travel and Seminar			244	244		244	99	343		24
25	Other Admin. Staff Transportation			2,973	2,973		2,973	1,824	4,797		25
26	Insurance-Prop.Liab.Malpractice			16,852	16,852		16,852	2,189	19,041		26
27	Other (specify):* Bad Debt/related pa			(583)	(583)		(583)	6,673	6,090		27
28	TOTAL General Administration	62,189	1,586	191,665	255,440	2,108	257,548	(31,771)	225,777		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	520,716	94,804	281,337	896,857	7,538	904,395	(26,372)	878,023		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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			6,004	6,004		6,004	62,372	68,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,220	15,220		15,220	86,203	101,423			32
33	Real Estate Taxes			33,663	33,663	(33,663)		34,344	34,344			33
34	Rent-Facility & Grounds			126,003	126,003	33,663	159,666	(159,666)				34
35	Rent-Equipment & Vehicles			9,325	9,325		9,325	5,513	14,838			35
36	Other (specify):*											36
37	TOTAL Ownership			190,215	190,215		190,215	28,766	218,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,415	7,538	30,953	(7,538)	23,415	(5,950)	17,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,300	71,300		71,300		71,300			42
43	Other (specify):* Day Training/Tran	7,142		273,023	280,165		280,165		280,165			43
44	TOTAL Special Cost Centers	7,142	23,415	351,861	382,418	(7,538)	374,880	(5,950)	368,930			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	527,858	118,219	823,413	1,469,490		1,469,490	(3,556)	1,465,934			45

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

Alden Springs
Report Period Beginning: 01/01/2012
Report Period Ending: 12/31/2012

IDPH Facility No. 0047191

Reclassifications - Pages 3 & 4, Column 5

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(3,757.00)	Employee Meals
	22	3,757.00	Employee Meals
22		(1,649.00)	Uniforms
	1	909.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	10	740.00	Uniforms
	11		Uniforms
	21		Uniforms
33		(33,662.72)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	33,662.72	Rent - Real Estate Tax on associated landowner (Pg 6)
DD Providers Only:			
39		(7,537.94)	PT, OT, & ST CPT Therapy Costs
	10A	7,537.94	PT, OT, & ST CPT Therapy Costs

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	(1,771)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,901)	21		17
18	Fines and Penalties	(15)	32		18
19	Entertainment	(23)	20		19
20	Contributions	(1,414)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	583	27		24
25	Fund Raising, Advertising and Promotional	(2,060)	20		25
	Income Taxes and Illinois Personal				
26	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)	\$ (6,601)		\$	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)	242,859	Various	34
35	Other- Attach Schedule	(239,814)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,045		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,556)		37

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

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

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

Alden Springs

Report Period Beginning:

ID#0047191

Ending:

01/01/2012

12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Late Fees on Utilities	\$ (140)	5	1
2	Intercompany Interest Not allowed (GL#7031)	(14,885)	32	2
3	Elim. MidCap Legal/Acctg fees	(341)	19	3
4				4
5	Back out 30% (for 2012) of PAC fees	(265)	20	5
6	Elim Deprec Exp on Pg 12 items under \$2,500 -	(42)	30	6
7	Elim Deprec Exp on Pg 13 items under \$2500 -	(1,764)	30	7
8	Expense Pg 12 items under \$2,500 - curr yr purchs +	0	6	8
9	Adj YTD Deprec Exp to Detail	42	30	9
10				10
11	Gain/Loss on FMV of Swap	(222,419)	32	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	(239,814)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	564	(499)	0	0	0	0	0	0	0	65	1
2	Food Purchase	0	0	0	(5,409)	0	0	0	0	0	0	0	(5,409)	2
3	Housekeeping	0	0	631	0	0	0	0	0	0	0	0	631	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(140)	0	359	0	0	0	0	0	0	0	0	219	5
6	Maintenance	(1,771)	0	4,595	0	0	0	280	0	0	0	0	3,104	6
7	Other (specify):*	0	0	701	213	0	0	0	0	0	0	0	914	7
8	TOTAL General Services	(1,911)	0	6,850	(5,695)	0	0	280	0	0	0	0	(476)	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	4,501	5	282	0	0	0	0	0	0	4,788	10
10a	Therapy	0	0	0	0	0	430	0	0	0	0	0	430	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	657	0	0	0	0	0	0	0	0	657	15
16	TOTAL Health Care and Programs	0	0	5,158	5	282	430	0	0	0	0	0	5,875	16
	C. General Administration													
17	Administrative	0	0	12,263	0	0	0	0	0	0	0	0	12,263	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(341)	1,175	(74,162)	0	0	0	0	0	0	0	0	(73,328)	19
20	Fees, Subscriptions & Promotions	(3,762)	250	(9,554)	0	0	0	0	0	0	0	0	(13,066)	20
21	Clerical & General Office Expenses	(1,901)	25	28,569	3,836	1,046	0	0	0	0	0	0	31,575	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	99	0	0	0	0	0	0	0	0	99	24
25	Other Admin. Staff Transportation	0	0	1,824	0	0	0	0	0	0	0	0	1,824	25
26	Insurance-Prop.Liab.Malpractice	0	2,161	28	0	0	0	0	0	0	0	0	2,189	26
27	Other (specify):*	583	0	5,623	437	30	0	0	0	0	0	0	6,673	27
28	TOTAL General Administration	(5,421)	3,611	(35,310)	4,273	1,076	0	0	0	0	0	0	(31,771)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,332)	3,611	(23,302)	(1,417)	1,358	430	280	0	0	0	0	(26,372)	29

Summary B

12/31/2012

													SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)		
Depreciation	(1,764)	54,526	9,610	0	0	0	0	0	0	0	0	62,372	30	
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31	
Interest	(237,319)	311,276	12,239	0	7	0	0	0	0	0	0	86,203	32	
Real Estate Taxes	0	33,663	671	0	10	0	0	0	0	0	0	34,344	33	
Rent-Facility & Grounds	0	(159,666)	0	0	0	0	0	0	0	0	0	(159,666)	34	
Rent-Equipment & Vehicles	0	0	5,513	0	0	0	0	0	0	0	0	5,513	35	
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36	
TOTAL Ownership	(239,083)	239,799	28,033	0	17	0	0	0	0	0	0	28,766	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38	
Ancillary Service Centers	0	0	0	(7,962)	2,012	0	0	0	0	0	0	(5,950)	39	
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40	
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41	
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42	
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43	
TOTAL Special Cost Centers	0	0	0	(7,962)	2,012	0	0	0	0	0	0	(5,950)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(246,415)	243,410	4,731	(9,379)	3,387	430	280	0	0	0	0	(3,556)	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:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 159,666	Alden Trails II, LLC		\$	(159,666)	1
2	V	19	Bank Charges		Alden Trails II, LLC		175	175	2
3	V	33	Real Estate Tax Expense		Alden Trails II, LLC		33,663	33,663	3
4	V	26	General Insurance Expense		Alden Trails II, LLC		2,161	2,161	4
5	V	32	Interest - Harris/Other		Alden Trails II, LLC		60,979	60,979	5
6	V	32	Interest - Mortgage		Alden Trails II, LLC		27,390	27,390	6
7	V	30	Depreciation		Alden Trails II, LLC		54,526	54,526	7
8	V	21	Miscellaneous Costs		Alden Trails II, LLC		25	25	8
9	V	20	Corporate Annual Report Fee		Alden Trails II, LLC		250	250	9
10	V	19	Professional Fees		Alden Trails II, LLC		1,000	1,000	10
11	V	32	Amortization Exprense		Alden Trails II, LLC		488	488	11
12	V	32	Gain/Loss on FMV of SWAP		Alden Trails II, LLC		222,419	222,419	12
13	V								13
14	Total			\$ 159,666			\$ 403,076	\$ * 243,410	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%	\$ 359	\$ 359	15
16	V	24	Trav & Seminar		Alden Management Services, Inc.		99	99	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,824	1,824	17
18	V	26	Insurance		Alden Management Services, Inc.		28	28	18
19	V	20	Dues & Subscriptions	9,840	Alden Management Services, Inc.		286	(9,554)	19
20	V	30	Depreciation		Alden Management Services, Inc.		9,610	9,610	20
21	V	33	Real Estate Tax		Alden Management Services, Inc.		671	671	21
22	V	35	Rent-Equip & Vehicles		Alden Management Services, Inc.		5,513	5,513	22
23	V	32	Interest		Alden Management Services, Inc.		12,239	12,239	23
24	V	1	Dietary		Alden Management Services, Inc.		564	564	24
25	V	3	Housekeeping		Alden Management Services, Inc.		631	631	25
26	V	7	Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		701	701	26
27	V	10	Nurs & Med Records Salary		Alden Management Services, Inc.		4,501	4,501	27
28	V	15	Employee Benefits-Health Care		Alden Management Services, Inc.		657	657	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		12,263	12,263	29
30	V	27	Employee Benefits-Admin		Alden Management Services, Inc.		5,623	5,623	30
31	V	19	Professional Fees	78,418	Alden Management Services, Inc.		4,256	(74,162)	31
32	V	21	Gen'l & Admin		Alden Management Services, Inc.		28,569	28,569	32
33	V	6	Repair & Maint	1,500	Alden Management Services, Inc.		6,095	4,595	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 89,758			\$ 94,489	\$ * 4,731	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consult.	\$ 1,200	Prism Health Care Sevices, Inc.	0.00%	\$ 5	\$ (1,195)	15
16	V	1	Dietary Salary		Prism Health Care Sevices, Inc.		696	696	16
17	V	2	Tube feeding	9,762	Prism Health Care Sevices, Inc.		4,353	(5,409)	17
18	V	10	Equip. Rental	360	Prism Health Care Sevices, Inc.		365	5	18
19	V	39	Ancillary supplies	14,437	Prism Health Care Sevices, Inc.		6,475	(7,962)	19
20	V	21	Gen'l & Admin Salary		Prism Health Care Sevices, Inc.		2,667	2,667	20
21	V	27	Employee benefits		Prism Health Care Sevices, Inc.		437	437	21
22	V	7	Employee benefits		Prism Health Care Sevices, Inc.		213	213	22
23	V	21	Gen'l & Admin		Prism Health Care Sevices, Inc.		1,169	1,169	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			\$ 25,759			\$ 16,380	\$ * (9,379)	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	39	Drugs	\$ 7,985	Forum Extended Care Services II, Inc.	0.00%	\$ 10,201	\$ 2,216	15
16	V	39	I.V.		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care	993	Forum Extended Care Services II, Inc.		789	(204)	17
18	V	10	House Stock	1,372	Forum Extended Care Services II, Inc.		1,269	(103)	18
19	V	10	Pharm Consult	384	Forum Extended Care Services II, Inc.		769	385	19
20	V	27	Employee Vaccin.	245	Forum Extended Care Services II, Inc.		194	(51)	20
21	V	27	Employee Benef: G & A		Forum Extended Care Services II, Inc.		81	81	21
22	V	21	Salary: G & A		Forum Extended Care Services II, Inc.		595	595	22
23	V	21	Gen'l & Admin.		Forum Extended Care Services II, Inc.		451	451	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		7	7	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		10	10	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			\$ 10,979			\$ 14,366	\$ * 3,387	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	10a	Therapy	\$ 7,538	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 7,968	\$ 430	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			\$ 7,538			\$ 7,968	\$ * 430	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repair & Maintenance	\$ 4,536	Alden Bennett Construction Company, Inc.	0.00%	\$ 4,816	\$ 280	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,536			\$ 4,816	\$ * 280	39

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

Facility Name & ID Number

Alden Springs

0047191

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	1
2			Alden-Lincoln Park Rehabilitation and Health Ca	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Care	Chicago	Forum Extended Care Se	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care (	Chicago	Alden Management Serv	Chicago	Management	4
5			Alden of Old Town East, Inc.	Bloomingtondale				5
6			Alden Terrace of McHenry Rehabilitation and He	McHenry	Alden Gardens of Bloom	Bloomingtondale	Supportive Living Fac	6
7			Alden - Wentworth Rehabilitation and Health Ca	Chicago	Alden Garden Courts of	DesPlaines	Assisted Living/Alzhei	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Waterfo	Aurora	Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health C	Bloomingtondale	Alden Gardens of Water	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Yo	Bloomingtondale	Prism Health Care Servi	Schaumburg	Nursing and Durable	10
11			Alden - Orland Park Rehabilitation and Health C	Orland Park	Community Physical The	Addison	Therapy Provider	11
12			Alden - Princeton Rehabilitation and Health Car	Chicago	Alden Bennett Construct	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable	13
14			Alden - Town Manor Rehabilitation and Health C	Cicero	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	14
15			Alden Trails, Inc.	Bloomingtondale				15
16			Alden - Poplar Creek Rehabilitation and Health (	Hoffman Estates				16
17			Alden - North Shore Rehabilitation and Health C	Skokie				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				29
30								30

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	President	CEO	100.00	184,227	0.168	0.42	Salary	\$ 773	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,353	0.168	0.42	Salary	287	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,355	0.168	0.42	Salary	165	6-7	3
4											4
5											5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of 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											10
11											11
12											12
13								TOTAL	\$ 1,225		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Springs# 0047191

Report Period Beginning:

01/01/2012Ending: 2/31/2012

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 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	1,340,098	35	\$ 85,836	\$	5,599	\$ 359	1
2	24	Trav & Seminar	Patient Days	1,340,098	35	23,644		5,599	99	2
3	25	Other Admin Travel	Patient Days	1,340,098	35	436,530		5,599	1,824	3
4	26	Insurance	Patient Days	1,340,098	35	6,589		5,599	28	4
5	20	Dues & Subscriptions	Patient Days	1,340,098	35	68,371		5,599	286	5
6	30	Depreciation	No of Providers/usage	35	35	340,112		1	9,610	6
7	33	Real Estate Tax	Patient Days/ysage	1,340,098	35	184,769		5,599	671	7
8	35	Rent-Equip & Vehicle	Patient Days	1,340,098	35	1,319,497		5,599	5,513	8
9	32	Interest	Patient Days/usage	1,340,098	35	2,398,912		5,599	12,239	9
10	1	Dietary Salary	Patient Days	1,340,098	35	135,080	135,080	5,599	564	10
11	3	Housekeeping Salary	Patient Days	1,340,098	35	151,028	151,028	5,599	631	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,340,098	35	167,731		5,599	701	12
13	10	Nurs & Med Records Salary	Patient Days/usage	1,340,098	35	1,186,643	1,186,643	5,599	4,501	13
14	15	Employee Benefits -Health Care	Patient Days	1,340,098	35	157,190		5,599	657	14
15	17	Administrative Salary	Patient Days/usage	1,340,098	35	3,283,025	3,283,025	5,599	12,263	15
16	27	Employee Benefits - Admin	Patient Days	1,340,098	35	1,345,837		5,599	5,623	16
17	19	Professional fees	Patient Days	1,340,098	35	1,018,709	751,716	5,599	4,256	17
18	21	Gen'I & Admin	Patient Days	1,340,098	35	6,837,958	6,125,097	5,599	28,569	18
19	6	Repair & Maint.	Patient Days	1,340,098	35	1,458,765	980,107	5,599	6,095	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 20,606,226	\$ 12,612,696		\$ 94,489	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Harris (GI 2512/2021/7044)		x	Mortgage	\$10,752.46	1/13/12	\$ 1,589,811	\$ Paid off	6/01/2012	6.0000	\$ 60,952	1	
2	MB Bank (GI 2513/2021/7055)		x	Mortgage	Varies	8/29/12	1,520,000	1,512,444	9/05/2022	3.5000	20,209	2	
3												3	
4	FMV of Derivative		x	Rate Swap interest							7,181	4	
5	Insurance Interest		x	Medical Malpractice/W.Comp/Prop.Crime							347	5	
	Working Capital												
6	Related party-AMS		x								12,239	6	
7	Related party-FECII		x								7	7	
8												8	
9	TOTAL Facility Related				\$10,752.46		\$ 3,109,811	\$ 1,512,444			\$ 100,935	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	Amortization-Fin/Refin Fee		x	Facility related							488	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 488	14	
15	TOTALS (line 9+line14)						\$ 3,109,811	\$ 1,512,444			\$ 101,423	15	

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

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

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

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 2011 report.		\$	29,000	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.)		\$	30,863	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,863	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,800	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	33,663	7	
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	681
		Total Real Estate Tax Expense, Sch V, Line 33		\$	34,344
Real Estate Tax Bill for Calendar Year:		2007	3,525	8	
		2008	26,564	9	
		2009	27,401	10	
		2010	28,181	11	
		2011	30,863	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 2011 \$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Alden Springs, Inc.

COUNTY
Dupage

FACILITY IDPH LICENSE NUMBER
004-7191

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. See attached (Supplement)	Related party-Alden Management	\$ 303,210.00	\$ 671.00
2. See attached (Supplement)	Related Party-Forum Extended Care	\$ 37,853.00	\$ 10.00
3. 02-23-300-024	Alden Trails II LLC	\$ 30,862.72	\$ 30,862.72
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 371,925.72	\$ 31,543.72

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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	Nursing facility	22,035	2006	\$ 398,630	1
2					2
3	TOTALS	22,035		\$ 398,630	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16			2006	\$ 1,583,599	\$ 39,590	40	\$ 39,590	\$	\$ 247,437
5				2006	69,510	1,738	40	1,738		10,862
6				2006	20,156	504	40	504		3,360
7										
8										
	Improvement Type**									
9	Wiring		2006	840	42	20	42			263
10										
11	Drywall Carpentry		2007	18,677	1,245	15	1,245			7,055
12	Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	2,313	10	2,313			13,878
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,715,910	\$ 45,432		\$ 45,432	\$	\$ 282,855	1
2	Forum Prof Ctr: Remodeling	1979	15,057		20			15,057	2
3	Forum Prof Ctr: Build Improv - multiple	1980	29,324		15			29,324	3
4	Forum Prof Ctr: Tennant Improv	1986	925		13			925	4
5	Forum Prof Ctr: AMS remodel	1990	6,289		10			6,289	5
6	Forum Prof Ctr: Roof	1994	3,317		16			3,317	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,170	73	16	73		1,170	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,848	14	10	14		1,816	8
9	Forum Prof Ctr: Remodel/electrical	2001	720	26	7	26		694	9
10	Forum Prof Ctr: bathroom remodel	2002	637	45	5	45		637	10
11	Forum Prof Ctr: remodel suites/etc.	2003	818	81	9	81		818	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,519	101	7	101		2,291	12
13	Forum Prof Ctr: Suite renovation	2005	509	(12)	10	(12)		590	13
14	Forum Prof Ctr: Superior installations, etc.	2006	121		4			121	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	489	59	7	59		389	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	420	51	7	51		284	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	854	82	7	82		264	17
18	Forum Prof Ctr: Building Renovations	2010	1,455	295	7	295		676	18
19	Forum Prof Ctr: Building Renovations	2011	6,379	648	7	648		802	19
20	Forum Prof Ctr: Building Renovations	2012	278	38	7	38		38	20
21	Alden Mgt Servs: Remodel suites	1993	6,764		7			6,764	21
22	Alden Mgt Servs: Remodel suites	2002	282		7			282	22
23	Alden Mgt Servs: Remodel suites	2003	6,115		7			6,115	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,802,201	\$ 46,933		\$ 46,933	\$	\$ 361,518	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$193,098	\$21,092	\$21,092	\$	various	\$88,085	71
72	Current Year Purchases	1,292	345	345		various	345	72
73	Fully Depreciated Assets	80,633	6	6		various	80,633	73
74								74
75	TOTALS	\$275,023	\$21,443	\$21,443	\$		\$169,063	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Related Party - AMS	Various	98-'02	3,911				3	3,911	79
80	TOTALS			\$3,911	\$	\$	\$		\$3,911	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,479,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$68,376	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$68,376	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)	\$534,492	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	New Generator	\$8,456	92
93			93
94			94
95		\$8,456	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.

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

**

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?

16. Rental Amount for movable equipment: \$ 9,332 Description: Copy Machine Lease & Various office equipment.

(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	\$ 230.42	\$ 2,765	17
18					18
19					19
20					20
21	TOTAL		\$ 230.42	\$ 2,765	21

10. Effective dates of current rental agreement:

Beginning 1/1/2007

Ending 11/1/2016

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

Fiscal Year Ending Annual Rent

12. 12/31/13 \$ Varies

13. 12/31/14 \$ Varies

14. 12/31/15 \$ Varies

* 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.

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

☒ NO

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

Skilled nursing on site.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				10,201		10,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39-1,39-3								12
13	Other (specify): <u>See Pg 16A</u>						7,264		7,264	13
14	TOTAL			\$		\$	\$ 17,465		\$ 17,465	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.

XIV. Special Services (Direct Cost)				Page 16	
				Col 5: PT,OT, & ST	
				Col 6: Supplies	
Line	Service	Col. 1:	Ref. No.	To Pg 16: Col. No.	
1.	OT		39-3	To Col 5	\$2,380.91
2.	ST		39-3	To Col 5	1,155.64
3.					
4.	PT		39-3	To Col 5	4,001.39
5.					
6.					
7.					
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities				(7,537.94)
					0.00
Less: OT, ST, & PT costs - reclassified to 10A for DD facilities					0.00
					0.00
Pharmacy Supplies per GL					7,984.86
Manual Input from Related Party- Forum Drugs					2,216.00
9.	Total to line 9 Pharmacy		See Pg 16A	To Col 6	10,200.86
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
HFS 3745 (N-4-99)					

13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT	To Col 5		
Other		15,430.19	
Manual Input: Related Party - Prism		(7,962.00)	From Page 6B
Manual Input: Related Party FECII - I.V.		0.00	From Page 6C
Manual Input: Related Party FECII - Wound Care Oxygen, from reclass worksheet (Pg 4A)		(204.00)	From Page 6C
13. Col 6: Supplies Total	To Col 6	-----	
		7,264.19	

13. Total Line 13, Column 8		7,264.19	

14. Total		17,465.05	
		=====	

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 12,401	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	383,363	383,363	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		2,112	6
7	Other Prepaid Expenses	2,396	2,396	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 385,759	\$ 400,272	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,674,106	14
15	Leasehold Improvements, at Historical Cost	18,677	18,677	15
16	Equipment, at Historical Cost	53,033	238,182	16
17	Accumulated Depreciation (book methods)	(23,173)	(394,160)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: CIP/Ref.Fee)	8,456	22,779	22
23	Other(specify): Due from affiliates	75,859	100,217	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 132,852	\$ 2,058,431	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 518,611	\$ 2,458,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 188,647	\$ 278,539	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,239	1,239	28
29	Short-Term Notes Payable		30,765	29
30	Accrued Salaries Payable	41,934	41,934	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,458	7,458	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,800	32
33	Accrued Interest Payable		4,838	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	2,713	2,713	36
37	Due to affiliates	66,560	66,560	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 308,551	\$ 465,846	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,481,679	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates-Wage allocation	66,260	66,260	43
44	FMV of Derivative		222,419	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 66,260	\$ 1,770,359	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 374,811	\$ 2,236,204	46
47	TOTAL EQUITY(page 18, line 24)	\$ 143,799	\$ 222,499	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 518,611	\$ 2,458,703	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 149,921	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded		3
4	after prior year report submitted:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 149,921	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,122)	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)	\$ (6,122)	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)	\$ 143,799	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Springs# 0047191Report Period Beginning: 01/01/2012Ending: 12/31/2012

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	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,190,345	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,190,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training</u>	273,023	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 273,023	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,463,368	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	212,406	31
32	Health Care	429,011	32
33	General Administration	255,440	33
	B. Capital Expense		
34	Ownership	190,215	34
	C. Ancillary Expense		
35	Special Cost Centers	311,118	35
36	Provider Participation Fee	71,300	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,469,490	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,122)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,122)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,190,345	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)	\$ 1,190,345	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 done 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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,057	1,152	35,974	31.23	3
4	Licensed Practical Nurses	1,914	2,068	55,343	26.76	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	480	480	9,806	20.43	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	65	71	1,541	21.70	13
14	Head Cook	4,495	4,527	55,031	12.16	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	650	650	11,885	18.28	17
18	Housekeepers	913	987	12,062	12.22	18
19	Laundry					19
20	Administrator	500	500	13,826	27.65	20
21	Assistant Administrator	78	78	2,524	32.36	21
22	Other Administrative	52	52	1,549	29.79	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)	40	40	390	9.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,849	23,538	276,495	11.75	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Facility/Transport	2,539	2,671	51,432	19.26	33
34	TOTAL (lines 1 - 33)	34,632	36,814	\$ 527,858 *	\$ 14.34	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	100/Monthly	\$ 1,200	1-3	35
36	Medical Director	296/Monthly	3,550	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/Monthly	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1860/Monthly	22,324	11-3	44
45	Social Service Consultant		420	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,878		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Josephine Dinizzo	Administrator	0	\$ 13,826	Workers' Compensation Insurance	\$ 15,178	IDPH License Fee	\$		
Harris, Yvonne	Assistant Administrator	0	2,524	Unemployment Compensation Insurance	8,677	Advertising: Employee Recruitment	73		
		0		FICA Taxes	36,533	Health Care Worker Background Check			
		0		Employee Health Insurance	2,339	(Indicate # of checks performed 3)	90		
		0		Employee Meals	3,757	Patient Background Checks 20	200		
		0		Illinois Municipal Retirement Fund (IMRF)*		Secretary of State/Citi-Annual report	430		
		0		Dental/Life Insurance	206	IHCA dues, less pac fees	619		
		0		Employee Drug Tests/Vaccinations	293	Collaborative Healthcare	406		
		0		Misc Payroll Costs/401K Match	603	Surety bond fees-Marsh USA Inc.	175		
		0		Employee Relations	111	Related party-AMS	286		
						Less: Public Relations Expense (	)		
						Non-allowable advertising (	)		
						Yellow page advertising (	)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 16,350	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 2,279	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$			Related party-AMS	99	
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount				ILL Council on long Term care	26	
Alden Management Services	Consulting Fees	\$	59,518				IL Healthcare Association	218	
AMS (Eliminated)	Allocated Legal Fees		18,900						
BDO Seidman/Baker Tilly VK	Accounting Fees		2,403				Entertainment Expense (	)	
Alden Group-MidCap (Eliminated)	Legal Fees/Acctg fee		341				(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 343	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 81,162	TOTAL			\$	

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None for 2012		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
Il. Health Care Assn. \$ 619
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 6,342 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

x
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 71,300
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 3,757
Indicate the amount. \$
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A