

		FOR BHF USE					

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

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: 0042010

Facility Name: Alden Des Plaines Rehab & HC

Address: 1221 East Golf Road Des Plaines 60016
Number City Zip Code

County: Cook

Telephone Number: (847) 768-1300 Fax # (847) 768-1668

HFS ID Number:

Date of Initial License for Current Owners: 10/31/2000

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,260</u>	1
2		Skilled Pediatric (SNF/PED)		<u>0</u>	2
3		Intermediate (ICF)		<u>0</u>	3
4		Intermediate/DD		<u>0</u>	4
5		Sheltered Care (SC)		<u>0</u>	5
6		ICF/DD 16 or Less		<u>0</u>	6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,260</u>	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	<u>1,414</u>	<u>5,481</u>	<u>9,367</u>	<u>16,262</u>	8
9	SNF/PED					9
10	ICF	<u>11,440</u>	<u>2,410</u>	<u>12</u>	<u>13,862</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,854</u>	<u>7,891</u>	<u>9,379</u>	<u>30,124</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.82%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 10/31/2000

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 110 and days of care provided 9,184

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	577,421	21,843	608	599,872	1,310	601,182	4,398	605,580			1
2	Food Purchase		314,812		314,812	(26,311)	288,501	(4,530)	283,971			2
3	Housekeeping	136,167	23,351		159,518	1,110	160,628	4,221	164,849			3
4	Laundry	57,767	21,021	35	78,823	70	78,893		78,893			4
5	Heat and Other Utilities			203,723	203,723		203,723	(1,153)	202,570			5
6	Maintenance	46,924		224,478	271,402	191	271,593	16,467	288,060			6
7	Other (specify):* security/related party			1,290	1,290		1,290	4,257	5,547			7
8	TOTAL General Services	818,279	381,027	430,134	1,629,440	(23,630)	1,605,810	23,660	1,629,470			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,424,994	180,283	5,270	2,610,547	(11,166)	2,599,381	38,938	2,638,319			10
10a	Therapy	46,603	2,901	25,418	74,922		74,922		74,922			10a
11	Activities	96,414	2,052	6,800	105,266	150	105,416		105,416			11
12	Social Services	51,337			51,337		51,337		51,337			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* related party							4,227	4,227			15
16	TOTAL Health Care and Programs	2,619,348	185,236	55,488	2,860,072	(11,016)	2,849,056	43,165	2,892,221			16
	C. General Administration											
17	Administrative	182,996			182,996		182,996	96,500	279,496			17
18	Directors Fees											18
19	Professional Services			902,918	902,918		902,918	(805,750)	97,168			19
20	Dues, Fees, Subscriptions & Promotions			90,062	90,062		90,062	(62,596)	27,466			20
21	Clerical & General Office Expenses	159,285	18,087	203,543	380,915	491	381,406	81,130	462,536			21
22	Employee Benefits & Payroll Taxes			695,704	695,704	15,868	711,572	(20,828)	690,744			22
23	Inservice Training & Education											23
24	Travel and Seminar			784	784		784	831	1,615			24
25	Other Admin. Staff Transportation			110	110		110	8,127	8,237			25
26	Insurance-Prop.Liab.Malpractice			161,238	161,238		161,238	9,430	170,668			26
27	Other (specify):* related party			337,713	337,713		337,713	(303,463)	34,250			27
28	TOTAL General Administration	342,281	18,087	2,392,072	2,752,440	16,359	2,768,799	(996,619)	1,772,180			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,779,908	584,350	2,877,694	7,241,952	(18,287)	7,223,665	(929,794)	6,293,871			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			38,577	38,577		38,577	274,623	313,200			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,845	116,845		116,845	148,502	265,347			32
33	Real Estate Taxes			540,055	540,055	(540,055)		543,538	543,538			33
34	Rent-Facility & Grounds			610,763	610,763	540,055	1,150,818	(1,150,818)				34
35	Rent-Equipment & Vehicles			14,133	14,133		14,133	24,198	38,331			35
36	Other (specify):* MIP							40,396	40,396			36
37	TOTAL Ownership			1,320,373	1,320,373		1,320,373	(119,561)	1,200,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		979,661	1,346,464	2,326,125	18,287	2,344,412	3,409	2,347,821			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,368	183,368		183,368		183,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		979,661	1,529,832	2,509,493	18,287	2,527,780	3,409	2,531,189			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,779,908	1,564,011	5,727,899	11,071,818		11,071,818	(1,045,946)	10,025,872			45

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

From Line	To Line	Amount	Description
2		(26,311)	Employee Meals
	22	26,311	Employee Meals
22			Uniform Reclass
	1	1,310	Uniform Reclass
	3	1,110	Uniform Reclass
	4	70	Uniform Reclass
	6	191	Uniform Reclass
	10	7,121	Uniform Reclass
	11	150	Uniform Reclass
	21	491	Uniform Reclass
10		(18,287)	Oxygen Cost Reclass
	39	18,287	Oxygen Cost Reclass
33		(540,055)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	540,055	Rent - Real Estate Tax on associated landowner (Pg 6)

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

Net (Should be zero) \$ 10,443

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,228)	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	(67,497)	30		9
10	Interest and Other Investment Income	(2,241)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,216)	2		13
14	Non-Care Related Interest	(2,865)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(14,912)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,643)	20		19
20	Contributions	(4,840)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,103)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(337,713)	27		24
25	Fund Raising, Advertising and Promotional	(16,536)	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)	\$ (474,794)		\$	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)	(425,464)		34
35	Other- Attach Schedule	(145,688)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (571,152)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,045,946)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Late fees on utilities	(3,251)	5	2
3	Flu Shots	(103)	21	3
4	Intercompany Interest	(1,735)	32	4
5	Misc Income (Record copies)	(1,814)	10	5
6	Misc Income (Jury Duty)	(42)	21	6
7	Vendor Discounts	(200)	10	7
8	Add back re tax ref for 2012	54	33	8
9	Elim Deprec on Pg 13 < \$2,500 items	(12,070)	30	9
10	Expense Pg 13 items< \$2,500 Curr Yr	13,793	6	10
11	Elim Deprec on Pg 12 < \$2,500 items	(1,063)	30	11
12	Expense Pg 12 items< \$2,500 Curr Yr	2,594	6	12
13	Adjust depreciation to Pg 13's	(981)	30	13
14	Adjust dor ABC profit	(8)	30	14
15	Back out LLC mtge int > CON asset limit	(78,550)	32	15
16	Back out LLC MIP exp > CON asset limit	(15,709)	36	16
17	Back out % of Empl Ben. For Personnel Director	(15,199)	22	17
18	Personnel Director (6701-100-001) portion to DPII	(31,404)	21	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	(145,688)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	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	1,713	2,685	0	0	0	0	0	0	0	4,398	1
2	Food Purchase	(6,216)	0	0	1,686	0	0	0	0	0	0	0	(4,530)	2
3	Housekeeping	0	0	4,221	0	0	0	0	0	0	0	0	4,221	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,251)	0	2,098	0	0	0	0	0	0	0	0	(1,153)	5
6	Maintenance	(2,841)	0	18,480	0	0	0	(167)	995	0	0	0	16,467	6
7	Other (specify):*	0	0	4,257	0	0	0	0	0	0	0	0	4,257	7
8	TOTAL General Services	(12,308)	0	30,769	4,371	0	0	(167)	995	0	0	0	23,660	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	(2,014)	0	35,125	7,437	(1,610)	0	0	0	0	0	0	38,938	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	4,227	0	0	0	0	0	0	0	0	4,227	15
16	TOTAL Health Care and Programs	(2,014)	0	39,352	7,437	(1,610)	0	0	0	0	0	0	43,165	16
	C. General Administration													
17	Administrative	0	0	96,500	0	0	0	0	0	0	0	0	96,500	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,103)	18,360	(823,007)	0	0	0	0	0	0	0	0	(805,750)	19
20	Fees, Subscriptions & Promotions	(23,019)	614	(40,191)	0	0	0	0	0	0	0	0	(62,596)	20
21	Clerical & General Office Expenses	(46,461)	24	127,567	0	0	0	0	0	0	0	0	81,130	21
22	Employee Benefits & Payroll Taxes	(15,199)	0	0	0	(5,629)	0	0	0	0	0	0	(20,828)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	831	0	0	0	0	0	0	0	0	831	24
25	Other Admin. Staff Transportation	0	0	8,127	0	0	0	0	0	0	0	0	8,127	25
26	Insurance-Prop.Liab.Malpractice	0	9,270	160	0	0	0	0	0	0	0	0	9,430	26
27	Other (specify):*	(337,713)	0	34,250	0	0	0	0	0	0	0	0	(303,463)	27
28	TOTAL General Administration	(423,495)	28,268	(595,763)	0	(5,629)	0	0	0	0	0	0	(996,619)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(437,817)	28,268	(525,642)	11,808	(7,239)	0	(167)	995	0	0	0	(929,794)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(81,619)	352,705	3,537	0	0	0	0	0	0	0	0	274,623	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85,391)	229,060	4,833	0	0	0	0	0	0	0	0	148,502	32
33	Real Estate Taxes	54	540,055	3,429	0	0	0	0	0	0	0	0	543,538	33
34	Rent-Facility & Grounds	0	(1,150,818)	0	0	0	0	0	0	0	0	0	(1,150,818)	34
35	Rent-Equipment & Vehicles	0	0	24,198	0	0	0	0	0	0	0	0	24,198	35
36	Other (specify):*	(15,709)	56,105	0	0	0	0	0	0	0	0	0	40,396	36
37	TOTAL Ownership	(182,665)	27,107	35,997	0	0	0	0	0	0	0	0	(119,561)	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	(34,992)	(56,715)	95,116	0	0	0	0	0	3,409	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	(34,992)	(56,715)	95,116	0	0	0	0	0	3,409	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(620,482)	55,375	(489,645)	(23,184)	(63,954)	95,116	(167)	995	0	0	0	(1,045,946)	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	\$ 1,150,818	Alden-Des Plaines Rehabilitation and Health Care Center, LLC	0.00%	\$	\$ (1,150,818)	1
2	V	32	Interest-RR & Facility loan	59,783	Alden-Des Plaines Rehabilitation and Health Care Center, LLC			(59,783)	2
3	V	21	Bank charges		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		24	24	3
4	V	19	Accounting fees/Legal Fees		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		18,360	18,360	4
5	V	33	Real estate taxes		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		540,055	540,055	5
6	V	26	Property & liability ins		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		9,270	9,270	6
7	V	36	Mortgage insurance		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		56,105	56,105	7
8	V	32	Interest on mortgage		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		280,537	280,537	8
9	V	30	Depreciation		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		352,705	352,705	9
10	V	32	Amortization		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		8,306	8,306	10
11	V	20	Corporate Annual Report Fee		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		614	614	11
12	V	20	Sureaty Bonds		Alden-Des Plaines Rehabilitation and Health Care Center, LLC				12
13	V	6	Repairs & Maintenance		Alden-Des Plaines Rehabilitation and Health Care Center, LLC				13
14	Total			\$ 1,210,601			\$ 1,265,976	\$ * 55,375	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 2,098	\$ 2,098	15
16	V	24 Trav & Seminar		Alden Management Services, Inc.		831	831	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		8,127	8,127	17
18	V	26 Insurance		Alden Management Services, Inc.		160	160	18
19	V	20 Dues & Subscriptions	41,868	Alden Management Services, Inc.		1,677	(40,191)	19
20	V	30 Depreciation		Alden Management Services, Inc.		3,537	3,537	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		3,429	3,429	21
22	V	35 Rent-Equip & Vehicles		Alden Management Services, Inc.		24,198	24,198	22
23	V	32 Interest		Alden Management Services, Inc.		4,833	4,833	23
24	V	1 Dietary		Alden Management Services, Inc.		1,713	1,713	24
25	V	3 Housekeeping		Alden Management Services, Inc.		4,221	4,221	25
26	V	7 Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		4,257	4,257	26
27	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		35,125	35,125	27
28	V	15 Employee Benefits-Health Care		Alden Management Services, Inc.		4,227	4,227	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		96,500	96,500	29
30	V	27 Employee Benefits-Admin		Alden Management Services, Inc.		34,250	34,250	30
31	V	19 Professional Fees	858,141	Alden Management Services, Inc.		35,134	(823,007)	31
32	V	21 Gen'l & Admin	57,360	Alden Management Services, Inc.		184,927	127,567	32
33	V	6 Repair & Maint	24,906	Alden Management Services, Inc.		43,386	18,480	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 982,275			\$ 492,630	\$ * (489,645)	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	\$	Prism Health Care Services, Inc.	0.00%	\$	\$	15
16	V	1	Dietary salaries		Prism Health Care Services, Inc.				16
17	V	2	Tube feeding	22,573	Prism Health Care Services, Inc.		14,843	(7,730)	17
18	V	10	Equipment rental-patient care	6,660	Prism Health Care Services, Inc.		11,380	4,720	18
19	V	39	Ancillary supplies	88,443	Prism Health Care Services, Inc.		35,066	(53,377)	19
20	V	1	G & A &Emp. Benefits		Prism Health Care Services, Inc.		2,685	2,685	20
21	V	2	G & A &Emp. Benefits		Prism Health Care Services, Inc.		9,416	9,416	21
22	V	10	Emp. Benefits-Dietary		Prism Health Care Services, Inc.		2,717	2,717	22
23	V	39	G & A &Emp. Benefits		Prism Health Care Services, Inc.		18,385	18,385	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			\$ 117,676			\$ 94,492	\$ * (23,184)	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	\$ 756,409	Forum Extended Care Services II, Inc.	0.00%	\$ 703,650	\$ (52,759)	15
16	V	39	I.V.	127,122	Forum Extended Care Services II, Inc.		118,255	(8,867)	16
17	V	39	Wound Care	4,665	Forum Extended Care Services II, Inc.		4,340	(325)	17
18	V	10	House Stock	20,440	Forum Extended Care Services II, Inc.		19,014	(1,426)	18
19	V	10	Pharm Consult.	2,640	Forum Extended Care Services II, Inc.		2,456	(184)	19
20	V	22	Employ. Vaccin.	5,629	Forum Extended Care Services II, Inc.			(5,629)	20
21	V	39	Employ. Vaccin.		Forum Extended Care Services II, Inc.		5,236	5,236	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			\$ 916,905			\$ 852,951	\$ * (63,954)	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	Revenue - therapy	\$ 1,318,860	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,413,976	\$ 95,116	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			\$ 1,318,860			\$ 1,413,976	\$ * 95,116	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	\$ 26,515	Alden Bennett Construction Company, Inc.	0.00%	\$ 26,348	\$ (167)	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			\$ 26,515			\$ 26,348	\$ * (167)	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	\$ 3,491	Alden Design Group, Inc.	0.00%	\$ 4,486	\$ 995	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			\$ 3,491			\$ 4,486	\$ * 995	39

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

Facility Name & ID Number

Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	FECS of Central Illino	Chicago	Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomingtondale	Alden Management Se	Chicago	Management	5
6			Alden Terrace of McHenry Rehabilitation and F	McHenry	Alden Gardens of Bloo	Bloomingtondale	Supportive Living F	6
7			Wentworth Rehabilitation and Health Care Cen	Chicago	Alden Garden Courts	DesPlaines	Assisted Living/Alzh	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health	Bloomingtondale	Alden Gardens of Wat	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingtondale	Prism Health Care Ser	Schaumburg	Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health	Orland Park	Community Physical T	Addison	Therapy Provider	11
12			Princeton Rehabilitation and Health Care Cent	Chicago	Alden Bennett Constr	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipme	Fort Atkinson, WI	Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, I	Chicago	Design & Engineeri	14
15			Alden Trails, Inc.	Bloomingtondale	Achieve Recovery and	Elmhurst	Rehab-substance ab	15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for S	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health	Skokie	Family Home Health S	Addison	Home health & hosp	17
18			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				18
19			Alden Estates of Evanston, Inc.	Evanston				19
20			Alden - Alma Nelson Manor, Inc.	Rockford				20
21			Alden - Park Strathmoor, Inc.	Rockford				21
22			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				22
23			Alden Estates of Barrington, Inc.	Barrington				23
24			Alden of Waterford, LLC	Aurora				24
25			Alden Springs, Inc.	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			Alden - Long Grove Rehabilitation and Health C	Long Grove				30

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 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	180,674	0.936	2.34	Salary	\$ 4,326	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	97,662	0.936	2.34	Salary	2,338	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	97,662	0.936	2.34	Salary	2,338	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	113,765	0.936	2.34	Salary	2,724	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	60,811	0.936	2.34	Salary	1,456	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	146,134	0.6786	2.34	Salary	2,475	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	\$ 15,657		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 Des Plaines Rehab & HC# 0042010

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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	34	\$ 95,438	\$	30,125	\$ 2,098	1
2	24	Travel & Seminar	Patient days	34	32,213		30,125	831	2
3	25	Other Admin Travel	Patient days	34	375,370		30,125	8,127	3
4	26	Insurance	Patient days	34	6,897		30,125	160	4
5	20	Dues/Subscriptions	Patient days	34	113,573		30,125	1,677	5
6	30	Depreciation	No. of providers	34	156,306		1	3,537	6
7	33	Real Estate Tax	Patient days/usage	34	176,959		30,125	3,429	7
8	35	Rent-Equip/Vehicles	Patient days	34	1,250,701		30,125	24,198	8
9	32	Interest	Patient days/usage	34	2,158,573		30,125	4,833	9
10	1	Dietary Aide Coordinator Salary	Patient days	34	72,994	72,994	30,125	1,713	10
11	3	Housekeeping Coordinator Salary	Patient days	34	242,795	242,795	30,125	4,221	11
12	7	Employee Benef % -Gen'l Servs	Patient days	34	217,281		30,125	4,257	12
13	10	Nurs/Med Records Salary	Patient days/usage	34	1,562,220	1,562,220	30,125	35,125	13
14	15	Employee Benef % - Health Care	Patient days	34	218,198		30,125	4,227	14
15	17	Administrative Salary	Patient days/usage	34	4,332,153	4,332,153	30,125	96,500	15
16	27	Employee Benef %-Administrativ	Patient days	34	1,674,148		30,125	34,250	16
17	19	Professional Fees	Patient days	34	1,213,223	909,774	30,125	35,134	17
18	21	Gen'l & Admin	Patient days/usage	34	7,611,926	6,744,406	30,125	184,927	18
19	6	Repairs & Maintenance	Patient days	34	1,835,211	1,239,870	30,125	43,386	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 23,346,179	\$ 15,104,212		\$ 492,630	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	Cambridge (GL 2505/7055)		X	Mortgage	\$43,503.85	10/1/2012	\$ 12,080,802	\$ 11,112,249	9/1/2047	2.5000	\$ 280,537	1
2				Int exp in excess of CON cap							(78,550)	2
3												3
4	Amort of Fin Fees (GL 1918)		X	Refinancing							1,735	4
5	Insurance Interest (GL7053)		X	Malpractice Insurance							8,306	5
	Working Capital											
6	Related party-AMS		X	Working Capital							4,833	6
7												7
8	Bank Leumi		X	Working Capital	varies	8/2012	1,011,970			4.5000	50,809	8
9	TOTAL Facility Related				\$43,503.85		\$ 13,092,772	\$ 11,112,249			\$ 267,670	9
	B. Non-Facility Related*											
10	Interest Income (GL 4975)		X								(2,241)	10
11	Interest Income on R.R.		X								(82)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (2,323)	14
15	TOTALS (line 9+line14)						\$ 13,092,772	\$ 11,112,249			\$ 265,347	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,396 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	533,615	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.)			\$	528,924	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(4,691)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	544,800	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.			\$	540,109	7
Real Estate Tax History:		Plus: Related Party Taxes - See Pg RE_Tax	\$	3,429	
		Total Real Estate Tax Expense, Sch V, Line 33	\$	543,538	
Real Estate Tax Bill for Calendar Year:		FOR BHF USE ONLY			
2011	448,368	8	13	FROM R. E. TAX STATEMENT FOR 2015	13
2012	469,683	9	14	PLUS APPEAL COST FROM LINE 5	14
2013	504,900	10	15	LESS REFUND FROM LINE 6	15
2014	533,615	11	16	AMOUNT TO USE FOR RATE CALCULATION	16
2015	544,800	12			
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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. See attached (Supplement)	Related party-Alden Management	\$ 172,398.00	\$ 3,429.00
2. 09-17-200-128-0000	Nursing facility	\$ 306,819.12	\$ 306,819.12
3. 09-17-200-129-0000	Nursing facility	\$ 222,104.57	\$ 222,104.57
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 701,321.69	\$ 532,352.69

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 51,490

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

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	nursing facility	51,490	2000	\$ 1,016,045	1
2					2
3	TOTALS	51,490		\$ 1,016,045	3

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2000	2000	\$ 9,685,956	\$ 242,149	40	\$ 174,652	\$ (67,497)	\$ 2,906,402	4
5		Adjustment to correct to CON costs (net=6,986,060)			(2,699,896)						5
6											6
7											7
8											8
	Improvement Type**										
9		ISS/Chicago Sound & Communication(vent alarm interface		2000	3,400		10			3,400	9
10		Alden Bennett Construction(multiple wireless install)		2001	4,894		10			4,894	10
11		Owners extras (change orders)		2000	524,876	26,244	20	26,244		430,838	11
12		Owners extras (change orders)		2000	12,972	648	20	648		10,642	12
13		ABC-parking lot sealcoat/stripe		2002	3,852		7			3,852	13
14		ABC-screened patio enclosure		2002	10,069		7			10,069	14
15		EWS Welding-alarm		2002	1,076		10			1,076	15
16		New Horizons-residents phones		2002	1,646		10			1,646	16
17		New Horizons-residents phones		2002	3,161		10			3,161	17
18		ABC-owners extras		2003	2,571	171	15	171		2,395	18
19		ABC-owners extras		2003	5,511	367	15	367		5,139	19
20		ABC [GT Mechanical]-Replace B1 compressor		2007	3,383		5			3,383	20
21		Mohawk-Calhoun Carpet Admin area		2007	2,747		5			2,747	21
22		ABC-New carpeting Nile Room		2007	6,053		5			6,053	22
23		ABC-New patio door operator		2007	4,046	405	10	405		3,814	23
24		GTMECH-Exhaust motor & wheel blade		2007	4,791	479	10	479		4,431	24
25		ABC-Removal & repair of hot water piping		2007	4,170	167	25	167		1,531	25
26		Replace Gas Oxygen Units		2008	9,275	928	10	928		7,965	26
27		GTMECH-Repair Boiler Pumps		2008	3,242	324	10	324		2,727	27
28											28
29		ABC - Pavement Asphalt		2010	11,722	1,465	8	1,465		9,279	29
30		Nursing Station Repair		2010	2,600		5			2,600	30
31		ABC - Repair Laundry Chute & Grease Interceptor		2010	8,248		5			8,248	31
32		ABC - HVAC Pump		2010	4,738	316	15	316		1,975	32
33		Smoke Vent Relocation (non-hvac)		2011	3,345	446	5	446		3,345	33
34		Fish Tank Repair		2011	3,700	555	5	555		3,700	34
35		Sprinkler Heads & Gauges Replaced		2011	7,072	707	10	707		3,653	35
36		Dampers, labeling		2012	6,750	675	10	675		2,869	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden-Des Plaines Rehabilitation and Health Care Center, Inc.

0042010

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	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	Doorway-Build Kitchen Storage Doorway	2013	\$ 4,091	\$ 205	20	\$ 205	\$	\$ 683	37
38	Doorway-Sprinkler Room	2013	2,887	144	20	144		504	38
39	Wall- Wall Refinish	2013	5,950	446	15	446		1,338	39
40	Motor - Laundry Iron Motor	2013	3,025	605	5	605		2,017	40
41	OT/PT Remodel Building Permit	2014	2,920	195	15	195		520	41
42	Fire Dampers - ABC	2014	17,384	1,738	10	1,738		3,766	42
43	Fire Alarm lights - ABC	2014	2,609	522	5	522		1,131	43
44	Sewer, Replaced	2015	2,500	125	20	125		229	44
45	Fire Dampers - ABC	2015	4,074	407	10	407		747	45
46	Repaired Sliding Door - ABC	2015	2,786	557	5	557		1,021	46
47	Repaired Sliding Door - ABC	2015	4,165	833	5	833		1,180	47
48	Motor for pump for boiler, ignitors and sensor - GT Mech	2015	3,009	602	5	602		652	48
49	Concrete / Paving Insallation PT/OT Room - ABC	2015	30,635	1,532	20	1,532		2,808	49
50	New Flooring Installation PT/OT Room - ABC	2015	39,702	1,985	20	1,985		3,639	50
51	Drywall/Painting Installation in PT/OT Room - ABC	2015	21,874	1,094	20	1,094		2,005	51
52	Install New Cabinets in PT/OT Room -ABC	2015	27,520	1,376	20	1,376		2,523	52
53	Install new Plumbing and Lighting Fixtures in PT/OT Room - ABC	2015	95,531	4,777	20	4,777		8,758	53
54	New Plumbing Piping Installation in PT/OT Room - ABC	2015	33,318	1,666	20	1,666		3,054	54
55	New HVAC System Installation in PT/OT Room - ABC	2015	30,493	1,525	20	1,525		2,796	55
56	New Electrical Wiring and Circuts Installed in PT/OT Room - AB	2015	109,751	5,488	20	5,488		10,061	56
57	Door Repairs, Corral Garbage Area - ABC	2016	4,351	580	5	580		580	57
58	Motor, Washing Machine -TOPNOT	2016	2,579	172	5	172		172	58
59	Rewire Electrical Panel - ABC	2016	2,840	473	5	473		473	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,099,964	\$ 303,093		\$ 235,596	\$ (67,497)	\$ 3,502,491	70

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

Facility Name & ID Number Heather Health Care Center Inc.

002-3945

Report Period Beginning:

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

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

1	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		\$ 8,099,964	\$ 303,093		\$ 235,596	\$ (67,497)	\$ 3,502,491	1
2	Forum Prof Ctr: Remodeling	1979	15,638		20			15,638	2
3	Forum Prof Ctr: Build Improv - multiple	1980	30,457		15			30,457	3
4	Forum Prof Ctr: Tennant Improv	1986	961		13			961	4
5	Forum Prof Ctr: AMS remodel	1990	6,532		10			6,532	5
6	Forum Prof Ctr: Roof	1994	3,445		16			3,445	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,215		16			1,215	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,919		10			1,919	8
9	Forum Prof Ctr: Remodel/electrical	2001	748		7			748	9
10	Forum Prof Ctr: bathroom remodel	2002	661		5			661	10
11	Forum Prof Ctr: remodel suites/etc.	2003	850		9			850	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,616		7			2,616	12
13	Forum Prof Ctr: Suite renovation	2005	528	(45)	10	(45)		528	13
14	Forum Prof Ctr: Superior installations, etc.	2006	126		4			126	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	508		7			508	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	436		7			436	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	887	95	10	95		626	17
18	Forum Prof Ctr: Building Renovations	2010	1,511		5			1,511	18
19	Forum Prof Ctr: Building Renovations	2011	6,625	532	10	532		3,327	19
20	Forum Prof Ctr: Building Renovations	2012	288	39	15	39		195	20
21	Forum Prof Ctr: Building Renovations	2013	432	62	7	62		175	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	440	44		44		100	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	455	121	10	121		172	23
24	Alden Mgt Servs: Remodel suites	1993	6,963		13			6,963	24
25	Alden Mgt Servs: Remodel suites	2002	290		11			290	25
26	Alden Mgt Servs: Remodel suites	2003	6,295					6,295	26
27	Alden Mgt Servs: Motor Controller PC Board	2014	86	17		17		44	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,190,876	\$ 303,958		\$ 236,461	\$ (67,497)	\$ 3,588,829	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	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 12D, Carried Forward		\$ 8,190,876	\$ 303,958		\$ 236,461	\$ (67,497)	\$ 3,588,829	1
2								2
3 Adj for ABC related party profit	2008	(53)	(6)		(6)		(51)	3
4 Adj for ABC related party profit	2010	(302)	(18)		(18)		(117)	4
5 Adj for ABC related party profit	2011	110	8		8		44	5
6 Adj for ABC related party profit	2012	417	20		20		90	6
7 Adj for ABC related party profit	2013	174	4		4		14	7
8 Adj for ABC related party profit	2014	(38)	(1)		(1)		(3)	8
9 Adj for ABC related party profit	2015	(154)	(14)		(14)		(21)	9
10 Adj for ABC related party profit	2016	(27)	(1)		(1)		(1)	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)		\$ 8,191,002	\$ 303,950		\$ 236,453	\$ (67,497)	\$ 3,588,785	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	\$ 667,229	\$ 69,779	\$ 69,779	\$	varies	\$ 338,152	71
72	Current Year Purchases	20,017	2,075	2,075		varies	1,573	72
73	Fully Depreciated Assets	882,808	4,893	4,893		varies	882,808	73
74								74
75	TOTALS	\$ 1,570,054	\$ 76,747	\$ 76,747	\$		\$ 1,222,533	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	2001	2001	\$ 49,826	\$	\$	\$		\$ 49,826	76
77	related party-AMS	Various	1998-2004	4,026					4,026	77
78										78
79										79
80	TOTALS			\$ 53,852	\$	\$	\$		\$ 53,852	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)	\$ 10,830,953	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 380,697	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,200	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (67,497)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,865,170	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 Des Plaines Rehab & HC
--------------------------------------	---

0042010

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Related party - cost is eliminated**

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?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 20,797 Description: copy machine GL 6861 and equipment lease GL 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	related party-PG 6A	various	\$ 792.00	\$ 9,504	17
18					18
19	Auto lease - gl 6890	various	0.00	0	19
20					20
21	TOTAL		\$ 792.00	\$ 9,504	21

10. Effective dates of current rental agreement:

Beginning 7/1/2001

Ending **6/30/2021**

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. **12/31/2017** **\$ varies**

13. 12/31/2018 \$ varies

14. 12/31/2019 \$ varies

*** 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)	\$			

- (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.

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	

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	\$		\$ 442,707	\$		\$ 442,707	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			55,494			55,494	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			811,573			811,573	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				703,650		703,650	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					23,523	310,874		334,397	13
14	TOTAL			\$		\$ 1,333,297	\$ 1,014,524		\$ 2,347,821	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	
XIV. Special Services (Direct Cost)				Col 6: Supplies	
Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.		
1.	OT	39-3	To Col 5	442,707.00	
2.	ST	39-3	To Col 5	55,494.00	
3.					
4.	PT	39-3	To Col 5	811,573.00	
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			756,409.00	
	Manual Input from Related Party- Forum Drugs			(52,759.00)	From Page 6C
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	- 703,650.00	
10.					
11.					
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	- 0.00	
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	- 0.00	
	Total Exceptional Care (Line 12, Col 8)			- 0.00	
13.	Other:	See Pg 16A			
13.	Col 5: Manual Input: Related Party - CPT		To Col 5	118,639.00	From Page 6D
	Other			- 259,941.00	
	Manual Input: Related Party - Prism			(34,991.00)	From Page 6B
	Manual Input: Related Party FECII - I.V.			(8,867.00)	From Page 6C
	Manual Input: Related Party FECII - Wound Care			(325.00)	From Page 6C
	Oxygen, from reclass worksheet (Pg 4A)				
13.	Col 6: Supplies Total		To Col 6	- 215,758.00	
13.	Total Line 13, Column 8			- 334,397.00	
14.	Total			- 2,347,821.00	

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	\$ 88,761	\$ 641,550	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 76,000)	1,956,000	1,956,000	3
4	Supply Inventory (priced at)	3,548	3,548	4
5	Short-Term Investments			5
6	Prepaid Insurance		71,744	6
7	Other Prepaid Expenses	28,992	28,992	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd party	36,248	355,214	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,113,549	\$ 3,057,048	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	611,822	728,196	15
16	Equipment, at Historical Cost	307,662	2,248,781	16
17	Accumulated Depreciation (book methods)	(780,016)	(6,420,658)	17
18	Deferred Charges	70,416	70,416	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		114,294	21
22	Other Long-Term Assets (spec Replace.Reserv		142,588	22
23	Other(specify): Due from Affiliate	6,751,127	6,035,865	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,961,011	\$ 13,609,423	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,074,560	\$ 16,666,471	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 373,721	\$ 373,721	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	300,979	300,979	28
29	Short-Term Notes Payable	57,307	300,535	29
30	Accrued Salaries Payable	573,681	573,681	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,663	20,663	31
32	Accrued Real Estate Taxes(Sch.IX-B)		544,800	32
33	Accrued Interest Payable	9,163	32,314	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp/Ins,d/t PA,SaleTx,etc.	126,369	126,369	36
37	Due to Affiliates	1,996,227	1,996,227	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,458,110	\$ 4,269,289	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,096,949	1,096,949	39
40	Mortgage Payable		10,869,021	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,096,949	\$ 11,965,970	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,555,059	\$ 16,235,259	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,519,501	\$ 431,212	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,074,560	\$ 16,666,471	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,667,199	1
2	Restatements (describe):		2
3	Allocate Personnel Director Salary	(31,404)	3
4	Intercompany Note	1,162,495	4
5	Non-allowable cost or revenue adjustments recorded	(6)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,798,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(278,783)	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)	\$ (278,783)	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)	\$ 4,519,501	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,630,101	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,630,101	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,513	6
7	Oxygen	4,853	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 131,366	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	571	12
13	Barber and Beauty Care	285	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,436	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,272	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,564	23
	D. Non-Operating Revenue		
24	Contributions	2,241	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,241	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19A	3,763	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,763	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,793,035	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,629,440	31
32	Health Care	2,860,072	32
33	General Administration	2,752,440	33
	B. Capital Expense		
34	Ownership	1,320,373	34
	C. Ancillary Expense		
35	Special Cost Centers	2,326,125	35
36	Provider Participation Fee	183,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,071,818	40
41	Income before Income Taxes (line 30 minus line 40)**	(278,783)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (278,783)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,384,207	44
45	Private Pay - Net Inpatient Revenue	1,176,449	45
46	Medicare - Net Inpatient Revenue	5,200,120	46
47	Other-(specify) Hospice	54,717	47
48	Other-(specify) Insurance/Sales Allowance	1,814,608	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,630,101	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 Des Plaines Rehab & HC # 0042010 Report Period Beginning 01/01/2016 Ending: 12/31/2016

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc. Income GL#4977 (discribe) (is offset against Sch.# V)	
Misc Income (Record copies)	\$ 1,813
Misc Income (Jury Duty)	\$ 42
Vendor Discounts	\$ 200
Gain on Sale of Assets	\$ 1,708

Line 28 Total:	<u><u>3,763</u></u>
----------------	---------------------

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	1,930	2,106	\$ 110,638	\$ 52.55	1
2	Assistant Director of Nursing	1,952	2,112	81,038	38.38	2
3	Registered Nurses	20,695	22,341	728,997	32.63	3
4	Licensed Practical Nurses	13,794	14,493	470,037	32.43	4
5	CNAs & Orderlies	61,240	65,827	861,648	13.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,339	2,636	46,603	17.68	8
9	Activity Director	1,920	2,160	38,208	17.69	9
10	Activity Assistants	4,314	4,109	58,207	14.17	10
11	Social Service Workers	2,552	2,811	72,193	25.68	11
12	Dietician					12
13	Food Service Supervisor	1,536	1,707	49,099	28.76	13
14	Head Cook	2,387	2,531	61,992	24.49	14
15	Cook Helpers/Assistants	34,029	37,006	466,330	12.60	15
16	Dishwashers					16
17	Maintenance Workers	1,315	1,500	46,924	31.28	17
18	Housekeepers	9,920	10,733	136,166	12.69	18
19	Laundry	5,257	5,747	57,767	10.05	19
20	Administrator	1,920	2,080	129,728	62.37	20
21	Assistant Administrator	1,400	1,520	53,269	35.05	21
22	Other Administrative	3,632	4,064	79,059	19.45	22
23	Office Manager	1,864	2,080	62,808	30.20	23
24	Clerical	3,051	3,144	29,714	9.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,384	3,600	126,194	35.05	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Unit Manager	712	854	13,289	15.56	33
34	TOTAL (lines 1 - 33)	181,142	195,160	\$ 3,779,908 *	\$ 19.37	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	Monthly	\$ 608	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	Monthly	2,640	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	46	2,640	11-3	44
45	Social Service Consultant	28	1,960	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	74	\$ 25,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4	\$ 1,548	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	5	812	10-3	52
53	TOTAL (lines 50 - 52)	9	\$ 2,360		53

STATE OF ILLINOIS

0042010

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

Facility Name & ID Number

Alden Des Plaines Rehab & HC

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Liga, Tiffany Marie

Administrator

0

\$ 45,000

Rickman, Tiffany

Administrator

0

86,073

Porto, Jennifer

Assistant Administrator

0

24,231

Green, Julie

Assistant Administrator

0

27,692

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 182,996

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Alden Management Services, Inc.

consulting fee

\$ 813,837

First Advantage

Tax Consulting

838

AMS (Eliminated)

Allocated Legal Fees

45,192

KPMG/C. Novotny

Cost reporting fee

216

Baker Tilly

Accounting Fees

18,249

Accurate Biometrics

Professional Services

280

Achieve Accreditation

Professional Services

8,390

Pogrund & Korey LLC

Professional Services

6,856

Carissa Griffith/Chicago Title Compa

Legal fees:Collections

844

Gozdecki Legal Services

Legal fees: Non-Collections

1,377

Mix Solutions

Professional Fees

6,839

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 902,918

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 139,774

Unemployment Compensation Insurance

40,276

FICA Taxes

281,551

Employee Health Insurance

68,302

Employee Meals

26,311

Illinois Municipal Retirement Fund (IMRF)*

Union health & welfare

102,390

Union pension

27,965

Dental/Life/401k match/Empl rel/Misc pr

18,158

EE drug tests/Vaccinations

6,845

Gardens /Crts Personnel Dir. e/b deduction

(15,199)

Related Party: Forum

(5,629)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 690,744

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,295

Health Care Worker Background Check

(Indicate # of checks performed 80)

2,441

Patient Background Checks

266

2,740

Related Party - AMS

1,677

Relias Leartning Center

2,873

Health Care Council of IL

10,560

Chicago Tribune

4,694

Corp Annual Report Fee

186

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 27,466

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Related Party - AMS

831

Seminar Expense

784

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,615

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Legal Fees Reported on Pg 21, Section C:	\$	47,412.78
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22		(1,544.00)
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	\$	676.78

In Detail:

Vendor Name	Invoice Date	Amount
GOZDEL Gozdecki, Del Giudi	04/11/16	372.74
GOZDEL Gozdecki, Del Giudi	02/09/16	144.08
GOZDEL Gozdecki, Del Giudi	02/09/16	159.96
TOTAL ALLOWABLE LEGAL FEES		676.78

Vendor Name	Invoice Date	Amount
CARGRI Crissa J Griffith	12/6/2016	700.00
KATKAT Katherine Katsoyann	12/6/2016	700.00
CHITIC PROPERTY SEARCH collec	1/4/2017	75.00
RECCOO RECORD RELEASE FR SUIT	12/12/2016	40.00
ARIFIS Claim for collection	8/30/2016	29.00

TOTAL Collection-NOT ALLOWABLE LEGAL FEES	1,544.00
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Vendor Name	Invoice Date	Amount
AMS Corp Legal Cost Alloc-'16	01/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	02/28/16	3,766.00
AMS Corp Legal Cost Alloc-'16	03/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	04/30/16	3,766.00
AMS Corp Legal Cost Alloc-'16	05/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	06/30/16	3,766.00
AMS Corp Legal Cost Alloc-'16	07/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	08/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	09/30/16	3,766.00
AMS Corp Legal Cost Alloc-'16	10/31/16	3,766.00
AMS Corp Legal Cost Alloc-'16	11/30/16	3,766.00
AMS Corp Legal Cost Alloc-'16	12/31/16	3,766.00

TOTAL Allocated Legal Fees	45,192.00
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Total Legal Cost	47,412.78
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XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>CNA: Yes RN/LPN: No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>Healthcare Council = \$10,560</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7.5</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>21,448</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>183,368</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>26,311</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> 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? <u>0</u>
d. Have vehicle usage logs been maintained? <u>No</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
|---|--|