		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0054189

Facility Name: ABINGTON OF GLENVIEW NURSING

Address: 3901 GLENVIEW ROAD (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: (847) 729-0000 **Fax #** (847) 729-1552

HFS ID Number:

Date of Initial License for Current Owners: 2/22/16

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA **Telephone Number:** (847) 675-3585
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 1/1/2020 to 12/31/2020 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) ELISHA ATKIN
(Title) MEMBER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,272	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,272	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			13,050	13,050	8
9	SNF/PED					9
10	ICF	8,603	14,067		22,670	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,603	14,067	13,050	35,720	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.83%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/16

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/16 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 192 and days of care provided 13,050

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	568,984	87,738	36,580	693,302		693,302		693,302			1
2	Food Purchase		405,496		405,496	(59,109)	346,387		346,387			2
3	Housekeeping	329,607	64,636		394,243		394,243		394,243			3
4	Laundry	88,591	14,138		102,729		102,729		102,729			4
5	Heat and Other Utilities			213,273	213,273		213,273		213,273			5
6	Maintenance	111,823	25,325	83,760	220,908		220,908		220,908			6
7	Other (specify):*			35,339	35,339		35,339		35,339			7
8	TOTAL General Services	1,099,005	597,333	368,952	2,065,290	(59,109)	2,006,181		2,006,181			8
	B. Health Care and Programs											
9	Medical Director			46,000	46,000		46,000		46,000			9
10	Nursing and Medical Records	3,900,439	483,991	17,831	4,402,261		4,402,261		4,402,261			10
10a	Therapy	1,858,797	4,454	1,364	1,864,615		1,864,615		1,864,615			10a
11	Activities	194,209	10,382		204,591		204,591		204,591			11
12	Social Services	122,265			122,265		122,265		122,265			12
13	CNA Training											13
14	Program Transportation			41,641	41,641		41,641		41,641			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,075,710	498,827	106,836	6,681,373		6,681,373		6,681,373			16
	C. General Administration											
17	Administrative	312,156		15,000	327,156		327,156	111,948	439,104			17
18	Directors Fees											18
19	Professional Services			315,385	315,385		315,385	(1,198)	314,187			19
20	Dues, Fees, Subscriptions & Promotions			85,043	85,043		85,043	(37,487)	47,556			20
21	Clerical & General Office Expenses	690,775	42,951	523,231	1,256,957		1,256,957	(508,497)	748,460			21
22	Employee Benefits & Payroll Taxes			1,396,639	1,396,639	59,109	1,455,748		1,455,748			22
23	Inservice Training & Education			1,220	1,220		1,220		1,220			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,588	9,588		9,588		9,588			25
26	Insurance-Prop.Liab.Malpractice			407,762	407,762		407,762	19,904	427,666			26
27	Other (specify):*			605,467	605,467		605,467	(605,467)				27
28	TOTAL General Administration	1,002,931	42,951	3,359,335	4,405,217	59,109	4,464,326	(1,020,797)	3,443,529			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,177,646	1,139,111	3,835,123	13,151,880		13,151,880	(1,020,797)	12,131,083			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID# ABINGTON OF GLENVIEW NURSING **#0054189 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	28,287	
	REPAIRS & MAINTENANCE		73	
	OUTSIDE SERVICES		8,220	
				36,580
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,811	
	ELECTRICITY		112,113	
	WATER		55,718	
	CABLE TV - LOBBY		9,631	
				213,273
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		20,770	
	PAINTING & DECORATING		188	
	BUILDING REPAIRS		5,441	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,374	
	ELEVATOR MAINTENANCE & REPAIR		18,288	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,809	
	FIRE SERVICE		13,890	
				83,760
7	**OTHER**			
	SCAVENGER		29,712	
	SECURITY SERVICE		5,627	
				35,339
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		46,000	46,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		11,146	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,685	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				17,831
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		-297	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	1,661	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				1,364
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# ABINGTON OF GLENVIEW NURSING **#0054189 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		41,641	
				41,641
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	15,000	15,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	107,877	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	207,508	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				315,385
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,242	
	EMPLOYEE WANT ADS	XIX F	31	
	CONTRIBUTIONS	VI 20 XIX F	22,245	
	DUES & SUBSCRIPTIONS	XIX F	18,758	
	LICENSES & PERMITS	XIX F	8,272	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	18,637	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,858	
	PATIENT BACKGROUND CHECKS	XIX F		
				85,043
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		112,755	
	EQUIPMENT REPAIR & MAINTENANCE		9,112	
	OUTSIDE CLERICAL SERVICES		349,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	22,930	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		28,934	
	MESSENGER SERVICE		0	
				523,231

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	614,022	
	UNEMPLOYMENT COMPENSATION	XIX D	23,358	
	WORKERS COMPENSATION INSURANCE	XIX D	188,542	
	HOSPITALIZATION INSURANCE	XIX D	533,591	
	EMPLOYEE BENEFITS - OTHER	XIX D	37,126	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				1,396,639
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		1,220	
				1,220
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G		
				0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		9,588	
				9,588
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		407,762	
				407,762
27	**OTHER**			
	BAD DEBTS	VI 24	605,467	
				605,467

GRAND TOTAL COLUMN 3 OTHER **3,835,123**

ABINGTON OF GLENVIEW NURSING
SCHEDULES
12/31/2020

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	405,496
LESS SALES TAX	0
NET FOOD	405,496
TOTAL PATIENT CENSUS	35,720
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	107,160
ADD # EMPLOYEE MEALS/DAY	50
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	18,300
PATIENT MEALS	107,160
ADD EMPLOYEE MEALS	18,300
TOTAL MEALS/YEAR	125,460
NET FOOD	405,496
DIVIDE TOTAL MEALS/YEAR	125,460
COST PER MEAL	3
TIMES EMPLOYEE MEALS	18,300
EMPLOYEE MEAL RECLASSIFICATION	**59,109**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING #0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,745	21,745		21,745	571,167	592,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			658,321	658,321		658,321	847,892	1,506,213			32
33	Real Estate Taxes							1,400,000	1,400,000			33
34	Rent-Facility & Grounds			2,807,349	2,807,349		2,807,349	(2,807,349)				34
35	Rent-Equipment & Vehicles			224,344	224,344		224,344		224,344			35
36	Other (specify):*							135,121	135,121			36
37	**TOTAL Ownership**			3,711,759	3,711,759		3,711,759	146,831	3,858,590			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		347,682		347,682		347,682		347,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,490	176,490		176,490		176,490			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		347,682	176,490	524,172		524,172		524,172			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,177,646	1,486,793	7,723,372	17,387,811		17,387,811	(873,966)	16,513,845			45

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,631)	30		9
10	Interest and Other Investment Income	(3,125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(22,930)	21		18
19	Entertainment		20		19
20	Contributions	(22,245)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(605,467)	27		24
25	Fund Raising, Advertising and Promotional	(15,242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(224,127)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (894,767)		$	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)	20,801		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 20,801		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (873,966)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ABINGTON OF GLENVIEW NURSING

ID# 0054189

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (222,929)	21	1
2				2
3	COLLECTIONS	(1,198)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(224,127)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	111,948	0	0	0	0	0	0	0	0	111,948	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,198)	0	0	0	0	0	0	0	0	0	0	(1,198)	19
20	Fees, Subscriptions & Promotions	(37,487)	0	0	0	0	0	0	0	0	0	0	(37,487)	20
21	Clerical & General Office Expenses	(245,859)	0	(262,638)	0	0	0	0	0	0	0	0	(508,497)	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	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	19,904	0	0	0	0	0	0	0	0	0	19,904	26
27	Other (specify):*	(605,467)	0	0	0	0	0	0	0	0	0	0	(605,467)	27
28	**TOTAL General Administration**	(890,011)	19,904	(150,690)	0	0	0	0	0	0	0	0	(1,020,797)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(890,011)	19,904	(150,690)	0	0	0	0	0	0	0	0	(1,020,797)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,631)	572,798	0	0	0	0	0	0	0	0	0	571,167	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,125)	851,017	0	0	0	0	0	0	0	0	0	847,892	32
33	Real Estate Taxes	0	1,400,000	0	0	0	0	0	0	0	0	0	1,400,000	33
34	Rent-Facility & Grounds	0	(2,807,349)	0	0	0	0	0	0	0	0	0	(2,807,349)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	135,121	0	0	0	0	0	0	0	0	0	135,121	36
37	**TOTAL Ownership**	(4,756)	151,587	0	0	0	0	0	0	0	0	0	146,831	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	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(894,767)	171,491	(150,690)	0	0	0	0	0	0	0	0	(873,966)	45

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
SEE PG 6- SUPPLEMENTAL		OAKRIDGE HEALTHCARE CENTER,LLC	HILLSIDE, ILL	ABINGTON OF GLENVIEW, PROP	GLENVIEW	REAL ESTATE
		MCALLISTER NURSING & REHAB LLC	COUNTRY CLUB HILS	MCALLISTER PROPERTY,LLC	COUNTRY CLUB HILLS	REAL ESTATE
				INNOVATIVE MGT	MORTON GROVE	MANAGEMENT
				OAKRIDGE PROPERTY, LLC	HILLSIDE	REAL ESTATE

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 2,807,349	ABINGTON OF GLENVIEW PROPERTIES, LLC		$	$ (2,807,349)	1
2	V								2
3	V	26	INSURANCE - PROPERTY				19,904	19,904	3
4	V	30	DEPRECIATION				572,798	572,798	4
5	V	32	AMORT LOAN COSTS				8,866	8,866	5
6	V	32	INTEREST				842,151	842,151	6
7	V	33	REAL ESTATE TAXES				1,400,000	1,400,000	7
8	V	36	M.I.P. INSURANCE				135,121	135,121	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,807,349			$ 2,978,840	$ * 171,491	14

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 349,500	INNOVATIVE MANAGEMENT COMPANY		$	$ (349,500)	15
16	V	17	MANAGEMENT FEES	15,000				(15,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATION-ELI ATKIN				15,271	15,271	19
20	V	17	ADMINISTRATION-JOEL ATKIN				7,632	7,632	20
21	V	21	CLERICAL-TZVI ATKIN				19,497	19,497	21
22	V	21	CLERICAL-SHULAMIT ATKIN				691	691	22
23	V	17	ADMINISTRATION-EMANUEL ATKIN				6,308	6,308	23
24	V	17	ADMINISTRATION-CEO				30,542	30,542	24
25	V	17	ADMINISTRATION-CFO				22,825	22,825	25
26	V	17	ADMINISTRATION CONTROLLER				11,890	11,890	26
27	V	17	ADMINISTRATION				32,480	32,480	27
28	V	21	CLERICAL				66,674	66,674	28
29	V	21	CLERICAL						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			$ 364,500			$ 213,810	$ * (150,690)	39

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Elisha Atkin	30.63						1
2	Jya Enterprises LLC	30.63						2
3	Falm/ Phil Stein	1.000						3
4	Dact management, LLC	16.00						4
5	Charles Serlin	0.825						5
6	Steve Grapsas	0.625						6
7	Ronald Stillman	0.625						7
8	Howard Stillman	0.625						8
9	Neal Cohen Revocable Trust	0.500						9
10	Leslie Abramson Trust	0.500						10
11	Millenium Metal Corp 401k Plan	0.500						11
12	Steven Covici	0.375						12
13	Jeffrey Feld	0.125						13
14	Cary Berman	0.005						14
15	Robert Ettner	2.000						15
16	Mark Goldstein	0.050						16
17	Ed Weiner	0.023						17
18	Mark Charman	0.050						18
19	Patricia Charman	0.050						19
20	Lorraine Weiner Revocable Trust	0.023						20
21	Jdw Investment Group (Martin Weine	0.050						21
22	Sanford Bokor Trust	4.990						22
23	Larry Schwartz	2.000						23
24	Z Healthcare LLC	0.500						24
25	Edward J Weiner Trust DTD	0.027						25
26	Edward J Weiner Trust DTD Lorr	0.027						26
27								27
28								28
29								29
30								30

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TZVI (STEVE) ATKIN		PURCHASING		SEE ATTACHED	8.22	21.04	SALARY	$ 19,497	21-7	1
2											2
3	ELISHA ATKIN		ADMINISTRATIV	30.63		8.22	21.04	SALARY	15,271	17-7	3
4											4
5	EMANUEL ETKIN		ADMINISTRATIVE			8.22	21.04	SALARY	6,308	17-7	5
6											6
7	JOEL ATKIN		ADMINISTRATIVE			8.22	21.04	SALARY	7,632	17-7	7
8											8
9	SHULAMIT ATKIN		ACCOUNT RECEIVABLE			12.6	33.33	SALARY	691	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 49,399		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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: INNOVATIVE MANAGEMENT COMPANY
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE ILL 60053
Phone Number: (708) 573-1100
Fax Number: (708) 573-1720

	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	17	ADMINISTRATION-ELI ATKIN	CENSUS DAYS	235,210	6	$ 100,556	$ 100,556	35,720	$ 15,271	1
2	17	ADMINISTRATION-JOEL ATKI	CENSUS DAYS	235,210	6	50,257	50,257	35,720	7,632	2
3	21	CLERICAL-TZVI ATKIN	CENSUS DAYS	235,210	6	128,387	128,387	35,720	19,497	3
4	21	CLERICAL-SHULAMIT ATKIN	CENSUS DAYS	235,210	6	4,550	4,550	35,720	691	4
5	17	ADMINISTRATION-EMANUEL	CENSUS DAYS	235,210	6	41,539	41,539	35,720	6,308	5
6	17	ADMINISTRATION-CEO	CENSUS DAYS	235,210	6	201,112	201,112	35,720	30,542	6
7	17	ADMINISTRATION-CFO	CENSUS DAYS	235,210	6	150,297	150,297	35,720	22,825	7
8	17	ADMINISTRATION CONTROLI	CENSUS DAYS	235,210	6	78,297	78,297	35,720	11,890	8
9	17	ADMINISTRATION	CENSUS DAYS	235,210	6	32,480	32,480	35,720	32,480	9
10	21	CLERICAL	CENSUS DAYS	235,210	6	439,036	439,036	35,720	66,674	10
11	21	CLERICAL	CENSUS DAYS	235,210	6	87,769	87,769		0	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	TOTALS					$ 1,314,280	$ 1,314,280		$ 213,810	25

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	RELATED PARTY:						$	$			$	1
2	CAMBRIDGE CAPITAL			MORTGAGE	$93,448.65	11/29/18	21,200,000	20,662,944	12/1/54	3.9500	842,151	2
3	LOAN COSTS			LOAN COSTS	W/O OVER LOAN		310,317	291,844			8,866	3
4												4
5	CAMBRIDGE REALTY		X	DEBT SERVICE ESCROW		11/29/18	651,341	651,341			156,973	5
	Working Capital											
6	VARIOUS MEMBERS	X		INTEREST ON CAPITAL							473,057	6
7	FIRST INSURANCE			INTEREST							1,078	7
8	FIFTH THIRD BANK		X	WORKING CAPITAL		8/31/17	300,000	829,820	REVOLV	PRIME+	27,213	8
9	TOTAL Facility Related				$93,448.65		$ 22,461,658	$ 22,435,949			$ 1,509,338	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 22,461,658	$ 22,435,949			$ 1,509,338	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 135,121 Line # 36

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

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 1,364,590	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.)		$ 1,364,590	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1,400,000	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.		$ 1,400,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016	357,986	9
2017	481,791	10
2018	583,877	11
2019	1,364,590	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ABINGTON OF GLENVIEW NURSING COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054189

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-32-401-167-0000	NURSING HOME	$ 1,364,590.16	$ 1,364,590.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,364,590.16	$ 1,364,590.16

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,817 B. General Construction Type: Exterior BRICK MASONRY Frame STEEL Number of Stories 3

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2017	$ 1,472,000	1
2					2
3	TOTALS			$ 1,472,000	3

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	192		2017	1989	$ 16,235,484	$ 416,294	39	$ 416,294	$	$ 988,698	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR REHAB			2017	9,960	255	39	255		542	9
10	TILING, MOLDING, & CHARI RAIL			2017	345,756	8,866	39	8,866		19,579	10
11	CABINETS AND COUNTERTOPS-BISTRO AREA			2017	30,000	769	39	769		1,698	11
12	CABINETS AND COUNTERTOPS-NURSE STATION			2017	20,000	513	39	513		1,133	12
13	CABINETS AND COUNTERTOPS-THERAPY AREA			2017	25,000	641	39	641		1,416	13
14	CABINETS AND COUNTERTOPS-BACK THERAPY AREA			2017	10,000	256	39	256		565	14
15	CABINETS AND COUNTERTOPS-RECEPTION DESK			2017	5,000	128	39	128		283	15
16	CABINETS AND COUNTERTOPS-FRONT LOBBY AREA			2017	10,000	257	39	257		567	16
17	FIRST FLOOR REMODEL-INTEGREL CONSTRUCT GEN CONTRA			2017	449,392	11,523	39	11,523		25,447	17
18	DIALYSIS ROOM-CARPENTRY/ DRYWALL/CEILLINGS, HVAC			2019	103,611	2,657	39	2,657		5,203	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

*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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									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)		$ 17,244,203	$ 442,159		$ 442,159	$	$ 1,045,131	70

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 193,770	$ 7,022	$ 19,378	$ 12,356		$ 69,272	71
72	Current Year Purchases	14,723	14,723	736	(13,987)		736	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		130,639	130,639				74
75	TOTALS	$ 208,493	$ 152,384	$ 150,753	$ (1,631)		$ 70,008	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										79
80	TOTALS			$	$	$	$		$	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)	$ 18,924,696	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 594,543	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 592,912	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,631)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,115,139	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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: $ 215,197 Description: SEE ATTACHED SCHEDULE
(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			$	$	17
18	ADMINISTRATIVE	2019 VOLVO	523.13	9,147	18
19					19
20					20
21	TOTAL		$ 523.13	$ 9,147	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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 ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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	39-2	# of prescrpts				330,585		330,585	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					17,097		0 17,097	13
14	TOTAL			$		$	$ 347,682		$ 347,682	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.

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 65,249	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,027,580)	2,928,423		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,827		6
7	Other Prepaid Expenses	38		7
8	Accounts Receivable (owners or related parties)	5,547,601		8
9	Other(specify): Insurance Escrow Deposit	200,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,793,138	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	208,493		16
17	Accumulated Depreciation (book methods)	(190,937)		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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,556	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,810,694	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 954,536	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	829,820		29
30	Accrued Salaries Payable	434,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	149,668		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	NOTE PAYABLE - SBA PPP	1,767,383		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,135,734	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	651,341		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO PROPCO	1,884,902		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,536,243	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,671,977	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,138,717	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,810,694	$	48

***(See instructions.)**

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,703,909	1
2	Restatements (describe):		2
3	PRIOR	(729,590)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,974,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,749,289)	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	(86,313)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,835,602)	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)**	$ 2,138,717	24 *

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,492,766	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,492,766	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	871,481	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 871,481	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	40	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	432	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)**	$ 472	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,125	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	1,492,179	28
28a	OUT OF PERIOD EXPENSES	778,499	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,270,678	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,638,522	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,065,290	31
32	Health Care	6,681,373	32
33	General Administration	4,405,217	33
	B. Capital Expense		
34	Ownership	3,711,759	34
	C. Ancillary Expense		
35	Special Cost Centers	347,682	35
36	Provider Participation Fee	176,490	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,387,811	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,749,289)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,749,289)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,298,536	44
45	Private Pay - Net Inpatient Revenue	3,903,553	45
46	Medicare - Net Inpatient Revenue	5,915,747	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	1,374,930	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,492,766	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,970	2,091	$ 122,161	$ 58.42	1
2	Assistant Director of Nursing	2,229	2,518	115,721	45.96	2
3	Registered Nurses	36,972	39,233	1,434,541	36.56	3
4	Licensed Practical Nurses	15,658	16,414	530,477	32.32	4
5	CNAs & Orderlies	67,208	73,134	1,296,059	17.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	42,570	46,853	1,858,797	39.67	8
9	Activity Director	3,818	4,123	90,505	21.95	9
10	Activity Assistants	6,882	7,357	103,704	14.10	10
11	Social Service Workers	3,984	4,123	122,265	29.65	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,091	80,440	38.47	13
14	Head Cook	7,432	8,564	142,675	16.66	14
15	Cook Helpers/Assistants	21,908	24,058	345,869	14.38	15
16	Dishwashers					16
17	Maintenance Workers	3,918	4,254	111,823	26.29	17
18	Housekeepers	19,544	21,956	329,607	15.01	18
19	Laundry	5,726	6,276	88,591	14.12	19
20	Administrator	5,592	6,292	312,156	49.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,045	2,091	78,429	37.51	23
24	Clerical	34,425	37,012	612,346	16.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,926	4,223	197,424	46.75	31
32	Other Health C: Care Plan Coord			122,433		32
33	Other(specify) Admitting	1,872	2,091	81,623	39.04	33
34	TOTAL (lines 1 - 33)	289,641	314,754	$ 8,177,646 *	$ 25.98	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 28,287	1-3	35
36	Medical Director	O	46,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,685	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		1,661	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 82,633		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RAFI ZIMMERMAN	ADMINISTRATOR	0	$ 109,799
MATTHEW MILLER	ASST ADMIN	0	72,450
CECILE CASTRO	OTHER ADMIN	0	100,291
YOSEF TSADOK	OTHER ADMIN	0	29,616
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 312,156

B. Administrative - Other

Description	Amount
	$
MANAGEMENT FEES	15,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		315,385
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 315,385

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 188,542
Unemployment Compensation Insurance		23,358
FICA Taxes		614,022
Employee Health Insurance		533,591
Employee Meals		59,109
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		37,126
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,455,748

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	31
Health Care Worker Background Check	1,858
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	22,245
MARKETING/ADV/PROMO	33,879
LICENSES/DUES/SUBSCRIPTIONS	23,050
TRUST/FRANCHISE/CONTRIB/ETC	(22,245)
Less: Public Relations Expense	(0)
Non-allowable advertising	(15,242)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,556

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

ABINGTON OF GLENVIEW NURSING
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
5/18/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	DEDUCTIBLE FOR LIABILITY INSURANCE	25,000
11/18/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	DEDUCTIBLE FOR LIABILITY INSURANCE	25,000
6/10/2020	ROBBINS SALOMON & PATT LTD	TAX CONSULTING	2,500
12/10/2019	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	711
8/24/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	5,020
11/20/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	10,000
12/31/2020	FIFTH THIRD BANK	RENEWAL LINE OF CREDIT	13,500
10/28/2020	MAGES & PRICE LLC CLIENT TRUST	LEGAL SETTLEMENT	12,000
12/21/2018	JOHNSON & ROUNDTREE PREMIUM, INC	LEGAL SETTLEMENT	25,000
	TOTAL		**118,731**

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 6,352 Line 10-2

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 176,490
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 59,109 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name:

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.