

		FOR BHF USE					

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

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0052530</u></p> <p>Facility Name: <u>Alden Courts of Shorewood</u></p> <p>Address: <u>700 West Black Road</u> <u>Shorewood</u> <u>60404</u> Number City Zip Code</p> <p>County: <u>Will</u></p> <p>Telephone Number: <u>(815)230-8600</u> Fax # <u>(815)230-8699</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/22/17</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mark Novotny</u> Telephone Number: <u>773-724-6362</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Derek Smart</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Alden Management Services, Inc., as agent</u></td> <td></td> </tr> <tr> <td></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Derek Smart</u>			(Title) <u>CFO, Alden Management Services, Inc., as agent</u>			(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number Alden Courts of Shorewood

0052530 Report Period Beginning: 01/01/2020 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	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	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less		0	6
7	50	TOTALS	50	18,300	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	144	675	3,123	3,942	8
9	SNF/PED					9
10	ICF	3,157	6,286	987	10,430	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,301	6,961	4,110	14,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.54%

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

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 02/26/2017

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 50 and days of care provided 3,123

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Alden Courts of Shorewood # 0052530 Report Period Beginning: 01/01/2020 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 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	163,256	16,083	4,196	183,535	1,012	184,547	(1,227)	183,320		1
2	Food Purchase		117,150		117,150	(9,760)	107,390	(7,044)	100,346		2
3	Housekeeping	69,886	27,972		97,858	464	98,322	5,013	103,335		3
4	Laundry		7,773		7,773	201	7,974		7,974		4
5	Heat and Other Utilities			72,958	72,958		72,958	444	73,402		5
6	Maintenance			58,192	58,192	127	58,319	9,324	67,643		6
7	Other (specify):* related party							2,321	2,321		7
8	TOTAL General Services	233,142	168,978	135,346	537,466	(7,956)	529,510	8,831	538,341		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,032,294	110,077	3,473	2,145,844	7,952	2,153,796	13,144	2,166,940		10
10a	Therapy		1,097	155	1,252		1,252		1,252		10a
11	Activities		2,172	5,758	7,930	102	8,032		8,032		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Res Att/rel party	4,024			4,024		4,024	2,001	6,025		15
16	TOTAL Health Care and Programs	2,036,318	113,346	15,386	2,165,050	8,054	2,173,104	15,145	2,188,249		16
	C. General Administration										
17	Administrative	123,985			123,985		123,985	61,409	185,394		17
18	Directors Fees										18
19	Professional Services			273,910	273,910		273,910	(241,382)	32,528		19
20	Dues, Fees, Subscriptions & Promotions			39,137	39,137		39,137	(35,140)	3,997		20
21	Clerical & General Office Expenses	66,547	6,823	116,254	189,624	(4,376)	185,248	85,001	270,249		21
22	Employee Benefits & Payroll Taxes			411,131	411,131	4,242	415,373	(2,638)	412,735		22
23	Inservice Training & Education										23
24	Travel and Seminar			907	907		907	306	1,213		24
25	Other Admin. Staff Transportation			60	60		60	2,738	2,798		25
26	Insurance-Prop.Liab.Malpractice			91,997	91,997		91,997	9,059	101,056		26
27	Other (specify):* related party			91,607	91,607		91,607	(67,287)	24,320		27
28	TOTAL General Administration	190,532	6,823	1,025,003	1,222,358	(134)	1,222,224	(187,934)	1,034,290		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,459,992	289,147	1,175,735	3,924,874	(36)	3,924,838	(163,958)	3,760,880		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Courts of Shorewood

#0052530

Report Period Beginning:

01/01/2020

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			88,515	88,515		88,515	328,332	416,847			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,286	14,286		14,286	374,395	388,681			32
33	Real Estate Taxes			120,920	120,920	(120,920)		122,985	122,985			33
34	Rent-Facility & Grounds			704,049	704,049	120,920	824,969	(824,969)				34
35	Rent-Equipment & Vehicles			9,631	9,631		9,631	10,980	20,611			35
36	Other (specify):* MIP							67,421	67,421			36
37	TOTAL Ownership			937,401	937,401		937,401	79,144	1,016,545			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		249,681	541,416	791,097	36	791,133	(47,347)	743,786			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,404	99,404		99,404		99,404			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		249,681	640,820	890,501	36	890,537	(47,347)	843,190			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,459,992	538,828	2,753,956	5,752,776		5,752,776	(132,161)	5,620,615			45

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

Alden Courts of Shorewood
 Period Beginning: 1/1/2020
 Period Ending: 12/31/2020

IDPH License No. 0052530

Reclassifications - Pages 3 & 4 (Column 5)

From Line	To Line	Amount	Description
2		(9,760.00)	Employee Meals
	22	9,760.00	Employee Meals
22		(5,518.00)	Uniform Reclass
	1	1,012.00	Uniform Reclass
	3	464.00	Uniform Reclass
	4	201.00	Uniform Reclass
	6	127.00	Uniform Reclass
	10	3,368.00	Uniform Reclass
	11	102.00	Uniform Reclass
	21	244.00	Uniform Reclass
10		(36.13)	Oxygen Cost Reclass
	39	36.13	Oxygen Cost Reclass
21		(4,620.00)	Team TSI expense Reclass
	10	4,620.00	Team TSI expense Reclass
33		(120,920.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	120,920.00	Rent - Real Estate Tax on associated landowner (Pg 6)
		-	

Note for internal purposes: check your reclasses on last year's file, as there may be reclasses specific to your facility.

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,485)	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	(7,850)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,947)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(5,174)	21		17
18	Fines and Penalties	(7)	32		18
19	Entertainment				19
20	Contributions	(907)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,607)	27		24
25	Fund Raising, Advertising and Promotional	(33,646)	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)	\$ (150,623)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,039		34
35	Other- Attach Schedule	(45,577)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,462		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (132,161)		37

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

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

(See instructions.)

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

Alden Courts of Shorewood

ID# 0052530

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilites	\$ (590)	5	1
2	Intercompany Interest	(14,162)	32	2
3	Vendor Discounts	(81)	10	3
4	Back Out Collaborative Healthcare /Flagstaff/AHCA	(731)	20	4
5	Back Out Broadcast Music Media	(250)	20	5
6				6
7				7
8	Eliminate deprec exp on Pg 12 items <\$2,500	(1,218)	30	8
9	Eliminate deprec exp on Pg 13 items <\$2,500	(9,273)	30	9
10	Expense capital items <\$2,500 on Pg 13 CSW	5,284	6	10
11	Expense Pg 5 Capital Items <\$2,500 on Pg 12 CSW	2,395	6	11
12	Eliminate Depreciation ADG Related Party	(19,648)	30	12
13	Elim deprec exp on Pg 12 for costs over cost cert	(7,376)	30	13
14	Correct YTD Depreciation	72	30	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
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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	(45,577)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020

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	(1,227)	0	0	0	0	0	0	0	(1,227)	1
2	Food Purchase	(2,947)	0	0	(4,097)	0	0	0	0	0	0	0	(7,044)	2
3	Housekeeping	0	0	5,013	0	0	0	0	0	0	0	0	5,013	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(590)	0	1,034	0	0	0	0	0	0	0	0	444	5
6	Maintenance	(806)	3,901	6,058	0	0	0	28	143	0	0	0	9,324	6
7	Other (specify):*	0	0	2,321	0	0	0	0	0	0	0	0	2,321	7
8	TOTAL General Services	(4,343)	3,901	14,426	(5,324)	0	0	28	143	0	0	0	8,831	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	(81)	0	13,603	548	(926)	0	0	0	0	0	0	13,144	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	2,001	0	0	0	0	0	0	0	0	2,001	15
16	TOTAL Health Care and Programs	(81)	0	15,604	548	(926)	0	0	0	0	0	0	15,145	16
	C. General Administration													
17	Administrative	0	0	61,409	0	0	0	0	0	0	0	0	61,409	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,180	(245,562)	0	0	0	0	0	0	0	0	(241,382)	19
20	Fees, Subscriptions & Promotions	(35,533)	30	363	0	0	0	0	0	0	0	0	(35,140)	20
21	Clerical & General Office Expenses	(5,174)	0	90,175	0	0	0	0	0	0	0	0	85,001	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(2,638)	0	0	0	0	0	0	(2,638)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	306	0	0	0	0	0	0	0	0	306	24
25	Other Admin. Staff Transportation	0	0	2,738	0	0	0	0	0	0	0	0	2,738	25
26	Insurance-Prop.Liab.Malpractice	0	8,959	100	0	0	0	0	0	0	0	0	9,059	26
27	Other (specify):*	(91,607)	0	24,320	0	0	0	0	0	0	0	0	(67,287)	27
28	TOTAL General Administration	(132,314)	13,169	(66,151)	0	(2,638)	0	0	0	0	0	0	(187,934)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(136,738)	17,070	(36,121)	(4,776)	(3,564)	0	28	143	0	0	0	(163,958)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(45,293)	362,507	11,118	0	0	0	0	0	0	0	0	328,332	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,169)	371,976	16,588	0	0	0	0	0	0	0	0	374,395	32
33	Real Estate Taxes	0	120,920	2,065	0	0	0	0	0	0	0	0	122,985	33
34	Rent-Facility & Grounds	0	(824,969)	0	0	0	0	0	0	0	0	0	(824,969)	34
35	Rent-Equipment & Vehicles	0	0	10,980	0	0	0	0	0	0	0	0	10,980	35
36	Other (specify):*	0	67,421	0	0	0	0	0	0	0	0	0	67,421	36
37	TOTAL Ownership	(59,462)	97,855	40,751	0	0	0	0	0	0	0	0	79,144	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	(15,147)	(8,127)	(24,073)	0	0	0	0	0	(47,347)	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	(15,147)	(8,127)	(24,073)	0	0	0	0	0	(47,347)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,200)	114,925	4,630	(19,923)	(11,691)	(24,073)	28	143	0	0	0	(132,161)	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 PG-Supp		See PG-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 Rental Income	\$ 824,969	Alden Estates of Shorewood, LLC	0.00%	\$	\$ (824,969)	1
2	V	32 Interest Income - RR	37	Alden Estates of Shorewood, LLC			(37)	2
3	V	19 Accounting/Professional Fees/Surety Bond/Legal Fees		Alden Estates of Shorewood, LLC		4,180	4,180	3
4	V	20 Dues & Subscription/Rprt Fee		Alden Estates of Shorewood, LLC		30	30	4
5	V	33 Real Estate Tax Expense		Alden Estates of Shorewood, LLC		120,920	120,920	5
6	V	26 General Insurance Expense		Alden Estates of Shorewood, LLC		8,959	8,959	6
7	V	36 Mortgage Insurance Premium		Alden Estates of Shorewood, LLC		67,421	67,421	7
8	V	32 Interest on Loan- Mortgage & other		Alden Estates of Shorewood, LLC		349,285	349,285	8
9	V	30 Depreciation Expense		Alden Estates of Shorewood, LLC		362,507	362,507	9
10	V	32 Amortization Exp		Alden Estates of Shorewood, LLC		22,728	22,728	10
11	V	6 Repairs & Maintenance		Alden Estates of Shorewood, LLC		3,901	3,901	11
12	V							12
13	V							13
14	Total		\$ 825,006			\$ 939,931	\$ * 114,925	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 1,034	\$ 1,034	15
16	V	24 Travel/Seminar		Alden Management Services, Inc.		306	306	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		2,738	2,738	17
18	V	26 Insurance		Alden Management Services, Inc.		100	100	18
19	V	20 Dues/Subscriptions		Alden Management Services, Inc.		363	363	19
20	V	30 Depreciation		Alden Management Services, Inc.		11,118	11,118	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		2,065	2,065	21
22	V	35 Rent-Equip & Vehicles		Alden Management Services, Inc.		10,980	10,980	22
23	V	32 Interest		Alden Management Services, Inc.		16,588	16,588	23
24	V	3 Housekeeping Salary		Alden Management Services, Inc.		5,013	5,013	24
25	V	7 Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		2,321	2,321	25
26	V	10 Nurs & Med Record Salary		Alden Management Services, Inc.		13,603	13,603	26
27	V	15 Employee Benefits-Health Care		Alden Management Services, Inc.		2,001	2,001	27
28	V	17 Administrative Salary		Alden Management Services, Inc.		61,409	61,409	28
29	V	27 Employee Benefits-Administr.		Alden Management Services, Inc.		24,320	24,320	29
30	V	19 Professional Fees	260,930	Alden Management Services, Inc.		15,368	(245,562)	30
31	V	21 Gen'l & Administrative	11,160	Alden Management Services, Inc.		101,335	90,175	31
32	V	6 Repairs & Maniten.	3,176	Alden Management Services, Inc.		9,234	6,058	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 275,266			\$ 279,896	\$ * 4,630	39

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

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Consult.	\$ 4,196	Prism Health Care Services, Inc.	0.00%	\$	\$ (4,196)
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		2,359	2,359
17	V	2 Tube feeding	7,854	Prism Health Care Services, Inc.		1,899	(5,955)
18	V	10 Equip. Rental		Prism Health Care Services, Inc.			
19	V	39 Ancillary supplies	25,809	Prism Health Care Services, Inc.		7,289	(18,520)
20	V	1 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		610	610
21	V	2 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		1,858	1,858
22	V	10 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		548	548
23	V	39 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		3,373	3,373
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 37,859			\$ 17,936	\$ * (19,923)

* 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	\$ 202,056	Forum Extended Care II, Inc.	0.00%	\$ 192,454	\$	(9,602)	15
16	V	39 I.V.	11,658	Forum Extended Care II, Inc.		11,104		(554)	16
17	V	39 Wound Care-Product only	10,159	Forum Extended Care II, Inc.		9,676		(483)	17
18	V	10 House Stock	18,921	Forum Extended Care II, Inc.		18,023		(898)	18
19	V	10 Pharm Consult	600	Forum Extended Care II, Inc.		572		(28)	19
20	V	22 Employee Vaccinations	2,638	Forum Extended Care II, Inc.				(2,638)	20
21	V	39 Employee Vaccinations		Forum Extended Care II, Inc.		2,512		2,512	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		\$ 246,032			\$ 234,341	\$ *	(11,691)	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 Therapy	\$ 532,674	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 508,601	\$ (24,073)	15
16	V							16
17	V	(Ln 10a for DD homes)						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		\$ 532,674			\$ 508,601	\$ * (24,073)	39

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

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 12,076	Alden Bennett Construction Company, Inc.	0.00%	\$ 12,104	\$	28	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		\$ 12,076			\$ 12,104	\$ *	28	39

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

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 155	Alden Design Group, Ltd.	0.00%	\$ 298	\$	143	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		\$ 155			\$ 298	\$ *	143	39

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

Facility Name & ID Number

Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020

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	The Alden Group, Ltd.	100	Heather Health Care Center, Inc.	Harvey	The Forum Professional	Chicago	Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Care	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	FECS of Central Illinois	Springfield	Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomington	Alden Management Ser	Chicago	Management	5
6			Alden Terrace of McHenry Rehabilitation and He	McHenry				6
7			Wentworth Rehabilitation and Health Care Cent	Chicago	Alden Garden Courts o	DesPlaines	Assisted Living/Alzh	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	SNF & Alzheimers F	8
9			Alden - Valley Ridge Rehabilitation and Health C	Bloomington	Alden Gardens of Water	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Yc	Bloomington	Prism Health Care Ser	Schaumburg	Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health C	Orland Park	Community Physical T	Addison	Therapy Provider	11
12			Princeton Rehabilitation and Health Care Center	Chicago	Alden Bennett Constr	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomington	Fort Medical Equipme	Fort Atkinson	Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health C	Cicero	Alden Design Group, I	Chicago	Design & Engineerin	14
15			Alden Trails, Inc.	Bloomington				15
16			Alden - Poplar Creek Rehabilitation and Health C	Hoffman Estates	Family Solutions for Se	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health C	Skokie	Family Home Health S	Addison	Home health & hosp	17
18			Alden - Des Plaines Rehabilitation and Health Ca	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.	Bloomington				25
26			Alden Village North, Inc.	Chicago	Alden Courts of Shore	Shorewood	SNF	26
27			Alden Estates of Skokie, Inc.	Skokie	Alden Estates-Courts o	Huntley	SNF	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 Courts of Shorewood # 0052530 Report Period Beginning: 01/01/2020 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 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 I	Chairman	100.00	182,801	0.476	1.19	Salary	\$ 2,199	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	98,811	0.476	1.19	Salary	1,189	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	98,811	0.476	1.19	Salary	1,189	6-7	3
4	Ina Schlossberg D.	Board Member	Board Member	0.00	112,458	0.476	1.19	Salary	1,353	17-7	4
5	Audra Elisco F.	Medical Records Cle	Medical records	0.00	62,689	0.476	1.19	Salary	754	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	182,801	0.476	1.19	Salary	2,199	6-7, 17-7	6
7	A. Floyd Schlossberg is the Chairman of the Board of Directors, Alden Management Services, Inc.										
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg.										
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg.										
10	D. Ina Schlossberg is the wife of Floyd Schlossberg.										
11	E. Audra Elisco is the daughter of Floyd Schlossberg.										
12	F. Randi Schlossberg-Schullo is the daughter of Floyd Schlossberg.										
13								TOTAL	\$ 8,883		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 Courts of Shorewood

0052530 Report Period Beginning: 01/01/2020

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 NO

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

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

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	1,209,117	36	\$ 86,976	\$ 14,372	\$ 1,034	1
2	24	Trav & Seminar	Patient Days	1,209,117	36	25,753	14,372	306	2
3	25	Other Admin Travel	Patient Days	1,209,117	36	230,320	14,372	2,738	3
4	26	Insurance	Patient Days	1,209,117	36	8,433	14,372	100	4
5	20	Dues & Subscriptions	Patient Days	1,209,117	36	30,557	14,372	363	5
6	30	Depreciation	No of Providers/usage	36	36	408,834	1	11,118	6
7	33	Real Estate Tax	Patient Days/usage	1,209,117	36	200,354	14,372	2,065	7
8	35	Rent-Equip & Vehicle	Patient Days	1,209,117	36	923,790	14,372	10,980	8
9	32	Interest	Patient Days/usage	1,209,117	36	1,567,343	14,372	16,588	9
10	3	Housekeeping Salary	Patient Days	1,209,117	36	421,760	421,760	5,013	10
11	7	Employee Benefits -Gen'I Servs	Patient Days	1,209,117	36	195,292	14,372	2,321	11
12	10	Nurs & Med Records Salary	Patient Days	1,209,117	36	1,149,694	1,149,694	13,603	12
13	15	Employee Benefits -Health Care	Patient Days	1,209,117	36	168,303	14,372	2,001	13
14	17	Administrative Salary	Patient Days/usage	1,209,117	36	5,264,790	5,264,790	61,409	14
15	27	Employee Benefits - Admin	Patient Days	1,209,117	36	2,046,057	14,372	24,320	15
16	19	Professional fees	Patient Days	1,209,117	36	1,372,458	1,094,350	15,368	16
17	21	Gen'I & Admin	Patient Days	1,209,117	36	8,525,354	7,617,708	101,335	17
18	6	Repair & Maint.	Patient Days	1,209,117	36	1,379,344	912,301	9,234	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 24,005,407	\$ 16,460,603	\$ 279,896	25

Facility Name & ID Number

Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020

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	Cambridge Realty Capital, Ltd.		x	Mortgage	\$42,119.17	11/1/17	\$ 9,870,300	\$ 9,292,375	1/2052	3.7300	\$ 349,285	1								
2												2								
3	Interest Capital Lease		x	Phone Lease							71	3								
4	Insurance Interest (7053)		x	Malpractice Insurance							46	4								
5	Amort of Fin Fees (7105)		x								22,728	5								
Working Capital																				
6	Related party - AMS		x	Working capital							16,588	6								
7												7								
8												8								
9	TOTAL Facility Related				\$42,119.17		\$ 9,870,300	\$ 9,292,375			\$ 388,718	9								
B. Non-Facility Related*																				
10	Interest Income on R.R.		x								(37)	10								
11	Interest Income (GL 4975)		x									11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (37)	14								
15	TOTALS (line 9+line14)						\$ 9,870,300	\$ 9,292,375			\$ 388,681	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 67,421 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2019 report.			\$	184,800 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.)			\$	150,620 2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(34,180) 3
4.	Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	155,100 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.			\$	120,920 7
Real Estate Tax History:				\$	2,065
				\$	122,985
Real Estate Tax Bill for Calendar Year:	2015		8		
	2016	144,831	9		
	2017	167,003	10		
	2018	179,375	11		
	2019	150,620	12		
<u>The current year accrual is based on an estimated 3% increase of the prior year tax.</u>					
				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 Alden Courts of Shorewood COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052530

CONTACT PERSON REGARDING THIS REPORT Mark Novotny

TELEPHONE 773-724-6362 FAX #: 872-469-1725

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>See attached (Supplement)</u>	<u>Related party - Alden Management</u>	\$ <u>173,696.00</u>	\$ <u>2,065.00</u>
2. <u>05-06-04-405-013-0000</u>	<u>Nursing Facility</u>	\$ <u>376,549.00</u>	\$ <u>150,620.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>550,245.00</u></u>	\$ <u><u>152,685.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,635 B. General Construction Type: Exterior Brick/Cement Frame Steel Skeleton/Metal F Number of Stories 1 + Basement

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing home facility</u>	<u>73,567</u>	<u>2006</u>	<u>\$ 571,894</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>73,567</u>		<u>\$ 571,894</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	50		2017	\$ 8,671,724	\$ 222,352	39	\$ 222,352	\$	\$ 889,408	4
5			2017	(306,135)		39	(7,850)	(7,850)	(31,400)	5
6			2017	1,352,929	34,690	39	34,690		138,760	6
7										7
8										8
Improvement Type**										
9	Building - (Additional Construction Costs - 306)		2017	295,051	7,565	39	7,565		30,260	9
10	ALDDES - Architectural Work		2017	8,762	225	39	225		900	10
11	AMS - Structural/Finishing Maintenance		2017	13,004	333	39	333		1,305	11
12	AMS - Structural/Finishing Maintenance		2017	9,528	244	39	244		936	12
13	ALDDES - Architectural Work		2017	13,778	353	39	353		1,353	13
14	ALDDES - Architectural Work		2017	4,486	115	39	115		431	14
15	AMS - Structural/Finishing Maintenance		2017	4,568	117	39	117		439	15
16	AMS - Structural/Finishing Maintenance		2017	10,016	257	39	257		964	16
17	DEDRES - Restoration, Flood Damage		2017	13,923	928	15	928		3,480	17
18	Building- (Additional after initial cost cert - Closing Oct 2017)		2017	1,027,219	26,339	39	26,339		105,356	18
19	Building Costs that could not be claimed on Cost Cert \$287,644.92		2017		(7,376)	39	(7,376)		(22,128)	19
20										20
21	CAT5RE - Floor Moulding, Flood Damage (Basement)		2019	23,040	1,536	15	1,536		1,920	21
22	AMS - Stain Furniture		2019	2,640	264	10	264		396	22
23										23
24	GTMECH - Repair RTU-1, HVAC (Roof)		2020	4,584	306	5	306		306	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 Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020 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	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		\$ 11,149,117	\$ 288,248		\$ 280,398	\$ (7,850)	\$ 1,122,686	1
2	Forum Prof Ctr: Remodeling	1979	14,770		20			14,770	2
3	Forum Prof Ctr: Build Improv - multiple	1980	28,765		15			28,765	3
4	Forum Prof Ctr: Tennant Improv	1986	908		13			908	4
5	Forum Prof Ctr: AMS remodel	1990	6,169		10			6,169	5
6	Forum Prof Ctr: Roof	1994	3,254		16			3,254	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,147		16			1,147	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,812		10			1,812	8
9	Forum Prof Ctr: Remodel/electrical	2001	706		7			706	9
10	Forum Prof Ctr: bathroom remodel	2002	624		5			624	10
11	Forum Prof Ctr: remodel suites/etc.	2003	803		9			803	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,471		7			2,471	12
13	Forum Prof Ctr: Suite renovation	2005	2,383		10			2,383	13
14	Forum Prof Ctr: Superior installations, etc.	2006	119		4			119	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	479		7			479	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	412		7			412	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	838		10			838	17
18	Forum Prof Ctr: Building Renovations	2010	1,427		5			1,427	18
19	Forum Prof Ctr: Building Renovations	2011	4,480	357	10	357		3,966	19
20	Forum Prof Ctr: Building Renovations	2012	272	2	15	2		262	20
21	Forum Prof Ctr: Building Renovations	2013	408	24	7	24		408	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	415	42	10	42		260	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	338	4	10	4		298	23
24	Forum Prof Ctr: Suite 116 walls/lighting/floor, renov.	2017	952	106	13	106		388	24
25	Forum Prof Ctr: Suite 140 Renov: fire sprinkler piping,drywall,duc	2018	20,628	1,423	15	1,423		3,563	25
26	Forum Prof Ctr: floors, walls,plumbing,hvac,carpentry	2019	1,239	127	10	127		212	26
27	Forum Prof Ctr: PktLot,door frames,windows	2020	541	32	3-10	32		32	27
28	Alden Mgt Servs: Remodel suites	1993	6,577		7			6,577	28
29	Alden Mgt Servs: Remodel suites	2002	274		13			274	29
30	Alden Mgt Servs: Remodel suites	2003	5,946		8			5,946	30
31	Alden Mgt Servs: MotorControl Board	2014	81		15			81	31
32	Alden Mgt Servs: Suite 140 Renov:walls,flooring,electrical,ceiling,	2018	37,755	2,579	15	2,579		6,417	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,296,110	\$ 292,944		\$ 285,094	\$ (7,850)	\$ 1,218,457	34

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

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning:

01/01/2020

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	\$ 1,150,895	\$ 130,861	\$ 130,861	\$	various	\$ 514,204	71
72	Current Year Purchases	13,520	867	867		various	867	72
73	Fully Depreciated Assets	87,621	25	25		various	87,621	73
74								74
75	TOTALS	\$ 1,252,036	\$ 131,753	\$ 131,753	\$		\$ 602,692	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	related party-AMS	various	1998-2004	3,802				3	3,802	77
78										78
79										79
80	TOTALS			\$ 3,802	\$	\$	\$		\$ 3,802	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)	\$ 13,123,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 424,697	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 416,847	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,850)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,824,951	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	Leasehold Improvements-ADG 12/31/18	\$ 766,264	\$ 19,648	\$ 39,296	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 766,264	\$ 19,648	\$ 39,296	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.

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

10. Effective dates of current rental agreement:

Beginning 2/1/17

Ending 2/1/27

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2021</u>	\$ <u>varies</u>
13.	<u>12/31/2022</u>	\$ <u>varies</u>
14.	<u>12/31/2023</u>	\$ <u>varies</u>

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

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

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 15,294 Description: copy machine \$9,631 and equipment lease \$5,663

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related party-PG 6A</u>	<u>various</u>	\$ <u>425.75</u>	\$ <u>5,109</u>	17
18					18
19	<u>Auto lease-GL 6890</u>		<u>0.00</u>	<u>0</u>	19
20					20
21	TOTAL		\$ <u>425.75</u>	\$ <u>5,109</u>	21

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

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

Facility Name & ID Number Alden Courts of Shorewood # 0052530 Report Period Beginning: 01/01/2020 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nursing on site</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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	

- (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		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39-3	hrs	\$				\$	244,716	\$			\$	244,716		1	
2	Licensed Speech and Language Development Therapist	39-3	hrs						68,871					68,871		2	
3	Licensed Recreational Therapist		hrs													3	
4	Licensed Physical Therapist	39-3	hrs						216,614					216,614		4	
5	Physician Care		visits													5	
6	Dental Care		visits													6	
7	Work Related Program		hrs													7	
8	Habilitation		hrs													8	
9	Pharmacy	See PG16A	# of prescripts							194,966				194,966		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10	
11	Academic Education		hrs													11	
12	Other (specify):															12	
13	Other (specify): <u>See PG16A</u>	39-1, 39-3, if any							(24,073)	42,693				18,620		13	
14	TOTAL			\$				\$	506,128	\$	237,659		\$	743,786		14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Page 16
 Col 5: PT,OT, & ST
 Col 6: Supplies

XIV. Special Services (Direct Cost)

Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.		
1.	OT	39-3	To Col 5	244,715.95	
2.	ST	39-3	To Col 5	68,870.91	
3.					
4.	PT	39-3	To Col 5	216,613.71	
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			202,055.75	
	Manual Input from Related Party- Forum Drugs & Vaccinations			(7,090.00)	From Page 6C. Ln 39, Col 8 Drug Items
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	194,965.75	
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: Transport. Specialist (6001-100-019)		See Pg 16A		
13.	Col 5: Manual Input: Related Party - CPT		To Col 5	(24,073.00)	From Page 6D, Col 8 (Except DD homes)
	Other			58,840.85	
	Manual Input: Related Party - Prism			(15,147.00)	From Page 6B/Ln 39 items, Col 8
	Manual Input: Related Party FECII - I.V.			(554.00)	From Page 6C/Ln 39 items for IV, Col 8
	Manual Input: Related Party FECII - Wound Care-Products Only			(483.00)	From Page 6C/Ln 39 items for Wound Care Products, Col 8
	Oxygen, from reclass worksheet (Pg 4A)			36.13	
13.	Col 6: Supplies Total		To Col 6	42,692.98	
13.	Total Line 13, Column 8			18,619.98	
14.	Total			743,786.30	

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>19,750</u>)	554,098	554,098	3
4	Supply Inventory (priced at <u> </u>)	51,280	51,280	4
5	Short-Term Investments			5
6	Prepaid Insurance		9,558	6
7	Other Prepaid Expenses	9,203	14,814	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>	3,726	187,045	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 618,307	\$ 816,795	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,567	1,567	12
13	Land			13
14	Buildings, at Historical Cost		9,698,943	14
15	Leasehold Improvements, at Historical Cost	2,521,070	2,546,505	15
16	Equipment, at Historical Cost	205,554	1,174,118	16
17	Accumulated Depreciation (book methods)	(301,852)	(1,743,965)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		119,083	21
22	Other Long-Term Assets (spe <u>Fin Fees, net</u>)		417,042	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,426,339	\$ 12,213,294	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,044,646	\$ 13,030,088	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 201,091	\$ 168,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	218,101	218,101	28
29	Short-Term Notes Payable		161,568	29
30	Accrued Salaries Payable	161,630	161,630	30
31	Accrued Taxes Payable (excluding real estate taxes)	88,401	88,401	31
32	Accrued Real Estate Taxes(Sch.IX-B)		155,100	32
33	Accrued Interest Payable		28,884	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Prov Rel,Accr Exp/Ins,due to IDPA,Sales</u>	1,112,327	1,112,327	36
37	<u>Due to Affiliates</u>	245,787	245,787	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,027,337	\$ 2,340,652	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	351,496	351,496	39
40	Mortgage Payable		9,130,807	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates</u>	2,221,961	1,606,189	43
44	<u>Mcr Adv Fund & Fica-Deferred</u>	60,630	60,630	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,634,087	\$ 11,149,122	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,661,424	\$ 13,489,774	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,616,778)	\$ (459,685)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,044,646	\$ 13,030,088	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,171,926)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,171,926)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(444,852)	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)	\$ (444,852)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,616,778)	24 *

* This must agree with page 17, line 47.

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

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

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,041,289	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,041,289	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	190,407	6
7	Oxygen	784	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 191,191	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,591	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,591	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG 19A	73,853	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 73,853	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,307,924	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	537,466	31
32	Health Care	2,165,050	32
33	General Administration	1,222,358	33
B. Capital Expense			
34	Ownership	937,401	34
C. Ancillary Expense			
35	Special Cost Centers	791,097	35
36	Provider Participation Fee	99,404	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,752,776	40
41	Income before Income Taxes (line 30 minus line 40)**	(444,852)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (444,852)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 675,934	44
45	Private Pay - Net Inpatient Revenue	2,054,867	45
46	Medicare - Net Inpatient Revenue	1,943,539	46
47	Other-(specify) Hospice	366,950	47
48	Other-(specify) Insur,Vets,Charity/Sales Allows		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,041,289	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 Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Wellness Fee	\$ 71,677
Vendor Discounts	81
Gain on Sale of Prior Year Assets	2,096

Line 28 Total: 73,853

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,239	2,239	\$ 106,411	\$ 47.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,624	24,238	886,596	36.58	3
4	Licensed Practical Nurses	4,768	4,880	137,471	28.17	4
5	CNAs & Orderlies	31,276	33,328	608,145	18.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,680	1,680	29,901	17.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,544	9,197	133,356	14.50	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	4,813	5,140	69,886	13.60	18
19	Laundry					19
20	Administrator	2,056	2,080	123,985	59.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,667	4,786	66,547	13.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,081	2,089	73,830	35.34	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Temp Nursing Ass	271	276	4,024	14.58	32
33	Other(specify) Memory Care Dire	11,770	12,353	219,840	17.80	33
34	TOTAL (lines 1 - 33)	96,789	102,286	\$ 2,459,992 *	\$ 24.05	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	\$ 4,196	1-3	35
36	Medical Director	Monthly	6,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	67	3,721	11-3	44
45	Social Service Consultant	16	1,120	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	83	\$ 15,637		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7	\$ 2,873	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7	\$ 2,873		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina K. Murdoch	Administrator	0	\$ 123,985	Workers' Compensation Insurance	\$ 77,203	IDPH License Fee	\$	
		0		Unemployment Compensation Insurance	10,411	Advertising: Employee Recruitment	1,969	
		0		FICA Taxes	181,553	Health Care Worker Background Check (Indicate # of checks performed 11)	357	
		0		Employee Health Insurance	91,354	Patient Background Checks 110	1,100	
		0		Employee Meals	9,760	Surety Bond Fees/Annual Report Fee	177	
		0		Illinois Municipal Retirement Fund (IMRF)*		Related party-Shorewood LLC (Annual Corp)	31	
		0		Dental/Life/Vision Insurance	853			
				Employee Drug Tests/Vaccinations	30,094			
				Employee Relations/Tuition Reimbursement	10,957			
				401K Match/Misc Payroll Costs	3,188	Related Party - AMS	363	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,985			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,997	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 412,735			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount				\$		
Alden Management Services, Inc.	Consulting Fees	\$ 245,069					Out-of-State Travel	\$
MidCap	Legal: Non-Collections	152						
AMS Eliminated Legal Fees	Allocated Legal Fees	15,840					In-State Travel	
Achieve Accreditation	Professional Consulting Fee	4,204						
MidCap	Accounting Fees	987					Related party - AMS	306
Baker Tilly	Accounting Fees	7,468					Seminar Expense	
C. Novotny/Internt'l Micro Design	Accounting Fees	190					WHCA/WICAL Spring & Fall Convention	639
							NIC Fall Conference	268
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 273,910		TOTAL		\$	TOTAL	\$ 1,213

* Attach copy of IMRF notifications

**See instructions.

Alden Courts of Shorewood
 Legal Fee Support
 2020

PG 21A

Legal Fees Reported on Pg 21, Section C:	\$	15,992.00
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22		-
Non-allowable legal fees, if any, deducted on		
- AMS Allocated Legal Fees: GL 680600-100-003		(15,840.00)
+ Add Back voided invoice of prior year, if any		
Allowable Legal Fees	\$	<u>152.00</u>

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
Mid-Cap Legal Fees	6/2020, 7/2020, 10/2020	152.00

TOTAL ALLOWABLE LEGAL FEES 152.00

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
--------------------	---------------------	---------------

TOTAL Collection-NOT ALLOWABLE LEGAL FEES -

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
AMS Allocated Legal Fees	1/1/20-12/31/20	15,840.00

TOTAL Allocated Legal Fees 15,840.00

Total Legal Cost 15,992.00

Facility Name & ID Number Alden Courts of Shorewood

0052530

Report Period Beginning: 01/01/2020

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? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,529 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 99,404
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. \$ 9,760 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes
Attach invoices and a summary of services for all architect and appraisal fees.