

		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>0054924</u></p> <p>Facility Name: <u>Alden Estates Cts of Huntley</u></p> <p>Address: <u>12140 Regency Parkwy</u> <u>Huntley</u> <u>60142</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847) 961-7500</u> Fax # <u>(872) 469-1791</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/26/18</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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 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>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></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></td> <td>Fax # <u>773-286-8038</u></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>		Paid Preparer	(Signed) _____	(Date) _____		(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 Estates Cts of Huntley

0054924 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	170	Skilled (SNF)	170	62,220	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	170	TOTALS	170	62,220	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	206	3,870	12,729	16,805	8
9	SNF/PED					9
10	ICF	3,825	4,789	54	8,668	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,031	8,659	12,783	25,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.94%

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 07/10/2018

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 170 and days of care provided 12,728

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 Estates Cts of Huntley # 0054924 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	901,522	43,667	2,334	947,522	4,676	952,198	(174)	952,024		1
2	Food Purchase		239,901		239,901	(21,603)	218,298	4,361	222,659		2
3	Housekeeping	267,124	81,307		348,431	2,141	350,572	8,885	359,457		3
4	Laundry	59,115	35,695		94,810	927	95,737		95,737		4
5	Heat and Other Utilities			293,375	293,375		293,375	(1,145)	292,230		5
6	Maintenance	137,307	2,353	263,773	403,433	586	404,019	13,583	417,602		6
7	Other (specify):* related party							4,114	4,114		7
8	TOTAL General Services	1,365,068	402,922	559,482	2,327,472	(13,273)	2,314,199	29,625	2,343,823		8
	B. Health Care and Programs										
9	Medical Director			24,021	24,021		24,021		24,021		9
10	Nursing and Medical Records	3,647,789	408,022	138,440	4,194,252	17,500	4,211,752	23,345	4,235,096		10
10a	Therapy		3,467		3,467		3,467		3,467		10a
11	Activities	110,094	8,330	3,530	121,955	470	122,425	(13)	122,412		11
12	Social Services	39,767			39,767		39,767		39,767		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Res Att/rel party	51,916			51,916		51,916	3,546	55,462		15
16	TOTAL Health Care and Programs	3,849,566	419,820	165,991	4,435,378	17,970	4,453,348	26,878	4,480,226		16
	C. General Administration										
17	Administrative	125,422			125,422		125,422	108,841	234,263		17
18	Directors Fees										18
19	Professional Services			626,350	626,350		626,350	(504,408)	121,942		19
20	Dues, Fees, Subscriptions & Promotions			235,109	235,109		235,109	(195,618)	39,491		20
21	Clerical & General Office Expenses	340,782	27,579	431,040	799,400	(3,492)	795,908	113,274	909,182		21
22	Employee Benefits & Payroll Taxes			966,260	966,260	(3,882)	962,378	(7,475)	954,903		22
23	Inservice Training & Education										23
24	Travel and Seminar			291	291		291	543	833		24
25	Other Admin. Staff Transportation			9,520	9,520		9,520	4,852	14,372		25
26	Insurance-Prop.Liab.Malpractice			229,994	229,994		229,994	20,956	250,949		26
27	Other (specify):* related party			115,912	115,912		115,912	(72,807)	43,105		27
28	TOTAL General Administration	466,204	27,579	2,614,475	3,108,257	(7,374)	3,100,883	(531,842)	2,569,041		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,680,838	850,321	3,339,948	9,871,107	(2,677)	9,868,430	(475,340)	9,393,090		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			192,329	192,329		192,329	999,251	1,191,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,911	42,911		42,911	1,150,870	1,193,781			32
33	Real Estate Taxes			478,239	478,239	(478,239)	0	481,898	481,898			33
34	Rent-Facility & Grounds			1,859,860	1,859,860	478,239	2,338,099	(2,338,099)	(0)			34
35	Rent-Equipment & Vehicles			40,442	40,442		40,442	19,462	59,904			35
36	Other (specify):* MIP							227,817	227,817			36
37	TOTAL Ownership			2,613,781	2,613,781		2,613,781	541,199	3,154,980			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,015,694	1,536,529	2,552,223	2,677	2,554,900	73,173	2,628,073			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,819	166,819		166,819		166,819			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,015,694	1,703,349	2,719,042	2,677	2,721,719	73,173	2,794,893			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,680,838	1,866,014	7,657,077	15,203,930		15,203,930	139,033	15,342,962			45

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

Alden Estates Cts of Huntley
 Period Beginning: 1/1/2020
 Period Ending: 12/31/2020

IDPH License No. 0054924

Reclassifications - Pages 3 & 4 (Column 5)

From Line	To Line	Amount	Description
2		(21,603.00)	Employee Meals
	22	21,603.00	Employee Meals
22		(25,485.00)	Uniform Reclass
	1	4,676.00	Uniform Reclass
	3	2,141.00	Uniform Reclass
	4	927.00	Uniform Reclass
	6	586.00	Uniform Reclass
	10	15,557.00	Uniform Reclass
	11	470.00	Uniform Reclass
	21	1,128.00	Uniform Reclass
10		(2,677.00)	Oxygen Cost Reclass
	39	2,677.00	Oxygen Cost Reclass
33		(478,239.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	478,239.00	Rent - Real Estate Tax on associated landowner (Pg 6)
21		(4,620.00)	Team TSI Expense Reclass
	10	4,620.00	Team TSI Expense Reclass

-

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 Estates Cts of Huntley

0054924

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	(209)	2		4
5	Telephone, TV & Radio in Resident Rooms	(21,498)	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	19,273	30		9
10	Interest and Other Investment Income	(257)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,192)	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	(17,493)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,341)	20		19
20	Contributions	(2,624)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,149)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,912)	27		24
25	Fund Raising, Advertising and Promotional	(191,549)	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)	\$ (346,951)		\$	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)	538,508		34
35	Other- Attach Schedule	(52,524)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 485,984		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 139,033		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 Estates Cts of Huntley

ID# 0054924

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilities	\$ (2,978)	5	1
2	Late fees on telephone		21	2
3	Intercompany interest	(39,353)	32	3
4	Commission		21	4
5	Jury Duty		21	5
6	Medical Records	(156)	10	6
7	Vendor Discounts	(195)	10	7
8	Backout Huntley/N. Kane Co. Chamber of Comm.	(825)	20	8
9	Depreciation Adjustment	1	30	9
10	Elim Deprec on Pg 13 < \$2,500 items	(3,285)	30	10
11	Expense Pg 13 items< \$2,500 Curr Yr	11,941	6	11
12	Elim Deprec on Pg 12 < \$2,500 items	(549)	30	12
13	Expense Pg 12 items< \$2,500 Curr Yr	2,348	6	13
14	Activity Supplies	(13)	11	14
15				15
16				16
17	Adj for 2018 ABC related party profit	2	30	17
18	Adj for 2019 ABC related party profit	55	30	18
19				19
20	Elimin Pg 13 deprec on Leasehold Improvement -2018	(19,518)	30	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	(52,524)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Estates Cts of Huntley

0054924

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)	
1	A. General Services													
1	Dietary	0	0	0	(174)	0	0	0	0	0	0	0	(174)	1
2	Food Purchase	(8,401)	0	0	12,762	0	0	0	0	0	0	0	4,361	2
3	Housekeeping	0	0	8,885	0	0	0	0	0	0	0	0	8,885	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,978)	0	1,832	0	0	0	0	0	0	0	0	(1,145)	5
6	Maintenance	(7,209)	0	10,184	0	0	0	41	10,567	0	0	0	13,583	6
7	Other (specify):*	0	0	4,114	0	0	0	0	0	0	0	0	4,114	7
8	TOTAL General Services	(18,588)	0	25,016	12,588	0	0	41	10,567	0	0	0	29,625	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	(351)	0	24,111	644	(1,059)	0	0	0	0	0	0	23,345	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13)	0	0	0	0	0	0	0	0	0	0	(13)	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	3,546	0	0	0	0	0	0	0	0	3,546	15
16	TOTAL Health Care and Programs	(363)	0	27,657	644	(1,059)	0	0	0	0	0	0	26,878	16
	C. General Administration													
17	Administrative	0	0	108,841	0	0	0	0	0	0	0	0	108,841	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,149)	57,345	(554,605)	0	0	0	0	0	0	0	0	(504,408)	19
20	Fees, Subscriptions & Promotions	(196,339)	77	644	0	0	0	0	0	0	0	0	(195,618)	20
21	Clerical & General Office Expenses	(17,493)	0	130,767	0	0	0	0	0	0	0	0	113,274	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(7,475)	0	0	0	0	0	0	(7,475)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	543	0	0	0	0	0	0	0	0	543	24
25	Other Admin. Staff Transportation	0	0	4,852	0	0	0	0	0	0	0	0	4,852	25
26	Insurance-Prop.Liab.Malpractice	0	20,778	178	0	0	0	0	0	0	0	0	20,956	26
27	Other (specify):*	(115,912)	0	43,105	0	0	0	0	0	0	0	0	(72,807)	27
28	TOTAL General Administration	(336,893)	78,200	(265,675)	0	(7,475)	0	0	0	0	0	0	(531,842)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(355,843)	78,200	(213,002)	13,232	(8,534)	0	41	10,567	0	0	0	(475,340)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Estates Cts of Huntley

0054924

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	(4,022)	992,155	11,118	0	0	0	0	0	0	0	0	999,251	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(39,610)	1,146,826	43,653	0	0	0	0	0	0	0	0	1,150,870	32
33	Real Estate Taxes	0	478,239	3,659	0	0	0	0	0	0	0	0	481,898	33
34	Rent-Facility & Grounds	0	(2,338,099)	0	0	0	0	0	0	0	0	0	(2,338,099)	34
35	Rent-Equipment & Vehicles	0	0	19,462	0	0	0	0	0	0	0	0	19,462	35
36	Other (specify):*	0	227,817	0	0	0	0	0	0	0	0	0	227,817	36
37	TOTAL Ownership	(43,632)	506,938	77,893	0	0	0	0	0	0	0	0	541,199	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	(23,235)	(39,155)	135,564	0	0	0	0	0	73,173	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	(23,235)	(39,155)	135,564	0	0	0	0	0	73,173	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(399,475)	585,138	(135,110)	(10,003)	(47,690)	135,564	41	10,567	0	0	0	139,033	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Revenue	\$ 2,338,099	Huntley Investments LLC	0.00%	\$	\$ (2,338,099)	1
2	V	32 Replacement Reserve Interest/Interest I	358	Huntley Investments LLC			(358)	2
3	V	19 Accounting Fees		Huntley Investments LLC		11,200	11,200	3
4	V	33 Real estate taxes		Huntley Investments LLC		478,239	478,239	4
5	V	26 Property/liability insurance		Huntley Investments LLC		20,778	20,778	5
6	V	36 Mortgage insurance premium		Huntley Investments LLC		227,817	227,817	6
7	V	32 Mortgage interest		Huntley Investments LLC		1,088,841	1,088,841	7
8	V	30 Depreciation		Huntley Investments LLC		992,155	992,155	8
9	V	19 Professional Fees		Huntley Investments LLC		46,145	46,145	9
10	V	20 Annual Report Fee		Huntley Investments LLC		77	77	10
11	V	32 Amortization Expenses		Huntley Investments LLC		58,343	58,343	11
12	V							12
13	V							13
14	Total		\$ 2,338,457			\$ 2,923,595	\$ * 585,138	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%	\$ 1,832	\$ 1,832	15
16	V	24 Travel/Seminar		Alden Management Services, Inc.		543	543	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		4,852	4,852	17
18	V	26 Insurance		Alden Management Services, Inc.		178	178	18
19	V	20 Dues/Subscriptions		Alden Management Services, Inc.		644	644	19
20	V	30 Depreciation		Alden Management Services, Inc.		11,118	11,118	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		3,659	3,659	21
22	V	35 Rent-Equip & Vehicles		Alden Management Services, Inc.		19,462	19,462	22
23	V	32 Interest		Alden Management Services, Inc.		43,653	43,653	23
24	V	3 Housekeeping Salary		Alden Management Services, Inc.		8,885	8,885	24
25	V	7 Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		4,114	4,114	25
26	V	10 Nurs & Med Record Salary		Alden Management Services, Inc.		24,111	24,111	26
27	V	15 Employee Benefits-Health Care		Alden Management Services, Inc.		3,546	3,546	27
28	V	17 Administrative Salary		Alden Management Services, Inc.		108,841	108,841	28
29	V	27 Employee Benefits-Administr.		Alden Management Services, Inc.		43,105	43,105	29
30	V	19 Professional Fees	596,650	Alden Management Services, Inc.		42,045	(554,605)	30
31	V	21 Gen'l & Administrative	48,840	Alden Management Services, Inc.		179,607	130,767	31
32	V	6 Repairs & Mainten.	2,160	Alden Management Services, Inc.		12,344	10,184	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 647,650			\$ 512,540	\$ * (135,110)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary Consult.	\$ 2,034	Prism Health Care Services, Inc.	0.00%	\$	(2,034)	15
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		1,144	1,144	16
17	V	2 Tube feeding	2,641	Prism Health Care Services, Inc.		13,221	10,580	17
18	V	10 Equip. Rental		Prism Health Care Services, Inc.				18
19	V	39 Ancillary supplies	39,795	Prism Health Care Services, Inc.		12,598	(27,197)	19
20	V	1 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		716	716	20
21	V	2 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		2,182	2,182	21
22	V	10 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		644	644	22
23	V	39 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		3,962	3,962	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		\$ 44,470			\$ 34,467	\$ * (10,003)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39 Drugs	\$ 855,657	Forum Extended Care II, Inc.	0.00%	\$ 814,997	\$	(40,660)	15
16	V	39 I.V.	113,433	Forum Extended Care II, Inc.		108,043		(5,390)	16
17	V	39 Wound Care-Product only	4,729	Forum Extended Care II, Inc.		4,504		(225)	17
18	V	10 House Stock	20,855	Forum Extended Care II, Inc.		19,864		(991)	18
19	V	10 Pharm Consult	1,440	Forum Extended Care II, Inc.		1,372		(68)	19
20	V	22 Employee Vaccinations	7,475	Forum Extended Care II, Inc.				(7,475)	20
21	V	39 Employee Vaccinations		Forum Extended Care II, Inc.		7,120		7,120	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,003,589			\$ 955,900	\$ *	(47,690)	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	\$ 1,487,865	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,623,429	\$ 135,564	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,487,865			\$ 1,623,429	\$ * 135,564	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Repairs & Maintenance	\$ 17,396	Alden Bennett Construction Company, Inc.	0.00%	\$ 17,437	\$ 41	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		\$ 17,396			\$ 17,437	\$ *	41 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Repairs & Maintenance	\$ 11,460	Alden Design Group, Ltd.	0.00%	\$ 22,027	\$ 10,567	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		\$ 11,460			\$ 22,027	\$ * 10,567	39

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

Facility Name & ID Number

Alden Estates Cts of Huntley

0054924

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	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 Constru	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 Estates Cts of Huntley # 0054924 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	181,103	0.844	2.11	Salary	\$ 3,897	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	97,893	0.844	2.11	Salary	2,107	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	97,893	0.844	2.11	Salary	2,107	6-7	3
4	Ina Schlossberg D.	Board Member	Board Member	0.00	111,644	0.844	2.11	Salary	2,398	17-7	4
5	Audra Elisco F.	Medical Records Cle	Medical records	0.00	59,263	0.844	2.11	Salary	1,337	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	181,103	0.7385	2.11	Salary	3,897	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	\$ 15,743		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 Estates Cts of Huntley

0054924

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	\$ 25,473	\$ 1,832	1
2	24	Trav & Seminar	Patient Days	1,209,117	36	25,753	25,473	543	2
3	25	Other Admin Travel	Patient Days	1,209,117	36	230,320	25,473	4,852	3
4	26	Insurance	Patient Days	1,209,117	36	8,433	25,473	178	4
5	20	Dues & Subscriptions	Patient Days	1,209,117	36	30,557	25,473	644	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	25,473	3,659	7
8	35	Rent-Equip & Vehicle	Patient Days	1,209,117	36	923,790	25,473	19,462	8
9	32	Interest	Patient Days/usage	1,209,117	36	1,567,343	25,473	43,653	9
10	1	Dietary Salary	Patient Days	1,209,117	36		25,473	0	10
11	3	Housekeeping Salary	Patient Days	1,209,117	36	421,760	421,760	8,885	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,209,117	36	195,292	25,473	4,114	12
13	10	Nurs & Med Records Salary	Patient Days	1,209,117	36	1,149,694	1,149,694	24,111	13
14	15	Employee Benefits -Health Care	Patient Days	1,209,117	36	168,303	25,473	3,546	14
15	17	Administrative Salary	Patient Days/usage	1,209,117	36	5,264,790	5,264,790	108,841	15
16	27	Employee Benefits - Admin	Patient Days	1,209,117	36	2,046,057	25,473	43,105	16
17	19	Professional fees	Patient Days	1,209,117	36	1,372,458	1,094,350	42,045	17
18	21	Gen'I & Admin	Patient Days	1,209,117	36	8,525,354	7,617,708	179,607	18
19	6	Repair & Maint.	Patient Days	1,209,117	36	1,379,344	912,301	12,344	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 24,005,407	\$ 16,460,603	\$ 512,540	25

Facility Name & ID Number

Alden Estates Cts of Huntley

0054924

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	CAPFUN		x	Mortgage	\$105,873.41	11/1/2016	\$ 26,584,000	\$ 25,766,629	4/1/2058	3.6800	\$ 953,575	1								
2	CAPFUN		x	Mortgage	\$15,018.20	4/1/2019	3,728,800	3,655,009	4/1/2058	3.6800	135,265	2								
3	Amort of Fin Fees (GL 1920)		x	Financing							58,343	3								
4	Insurance Interest		x	Medical Malpractice							116	4								
5												5								
Working Capital																				
6	Related party - AMS		x	Working capital							43,654	6								
7												7								
8	Capital Lease Obligation (GL 7105/703	x		Capital Lease							3,442	8								
9	TOTAL Facility Related				\$120,891.61		\$ 30,312,800	\$ 29,421,638			\$ 1,194,396	9								
B. Non-Facility Related*																				
10	Interest Income on R.R.		x								(358)	10								
11	Interest Income (GL 4975)		x								(257)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (615)	14								
15	TOTALS (line 9+line14)						\$ 30,312,800	\$ 29,421,638			\$ 1,193,781	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 227,817 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.	\$	450,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	457,239	2
3. Under or (over) accrual (line 2 minus line 1).	\$	7,239	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	471,000	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.	\$	478,239	7
Real Estate Tax History:	\$	3,659	
	\$	481,898	

Real Estate Tax Bill for Calendar Year:	2015	8			
	2016	9			
	2017	37,592	10	13	FROM R. E. TAX STATEMENT FOR 2019 \$
	2018	38,995	11	14	PLUS APPEAL COST FROM LINE 5 \$
	2019	457,239	12	15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

The current year accrual is based on an estimated 3% increase of the prior year tax.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Estates Cts of Huntley COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0054924

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>200,354.23</u>	\$ <u>3,659.32</u>
2. <u>02-05-276-010</u>	<u>Nursing Facility</u>	\$ <u>457,239.08</u>	\$ <u>457,239.08</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>657,593.31</u></u>	\$ <u><u>460,898.40</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: 115,096 B. General Construction Type: Exterior Face - Brick, Stone & C Frame Steel Number of Stories 3

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing home facility</u>	<u>321,386</u>	<u>2017</u>	<u>\$ 1,714,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	321,386		\$ 1,714,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	170		2018	\$ 30,114,321	\$ 752,889	39	\$ 772,162	\$ 19,273	\$ 1,985,867	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Facility Furnishing - ALDDDES		2018	35,603	3,560	10	3,560		9,197	9
10	Electrical Site - ALDBEN		2018	56,263	2,813	20	2,813		7,267	10
11	Asphalt Paving - ALDBEN		2018	88,645	2,273	39	2,273		5,872	11
12	Carpentry - ALDBEN		2018	38,838	996	39	996		2,573	12
13	Concrete - ALDBEN		2018	536,315	13,752	39	13,752		35,526	13
14	Custom Millwork - ALDBEN		2018	23,667	607	39	607		1,568	14
15	Electrical Site - ALDBEN		2018	264,877	6,792	39	6,792		17,546	15
16	Elevator Lockout Installation - ALDBEN		2018	3,320	85	39	85		220	16
17	Excavation - ALDBEN		2018	19,661	504	39	504		1,302	17
18	Finish Carpentry - ALDBEN		2018	30,520	783	39	783		2,022	18
19	Fire Protection - ALDBEN		2018	159,412	4,087	39	4,087		10,558	19
20	Flooring - Tile & Carpet - ALDBEN		2018	495,907	12,716	39	12,716		32,849	20
21	Hollow Metal Doors/Framing - ALDBEN		2018	2,840	73	39	73		188	21
22	HVAC & Gas Piping - ALDBEN		2018	462,745	11,865	39	11,865		30,651	22
23	Landscaping - ALDBEN		2018	262,083	6,720	39	6,720		17,360	23
24	Plumbing - ALDBEN		2018	39,973	1,025	39	1,025		2,648	24
25	Sewer & Water - ALDBEN		2018	372,910	9,562	39	9,562		24,702	25
26	Solid Surface - ALDBEN		2018	57,798	1,482	39	1,482		3,829	26
27	Special Construction (Flagpoles, Signage, Pond Aerator) - ALDBEN		2018	77,336	1,983	39	1,983		5,123	27
28	Wallcovering Repair - ALDBEN		2018	3,427	685	5	685		1,770	28
29										29
30	Roof Insulation, Roof - ALDBEN		2019	4,679	468	10	468		858	30
31	Dryer Repair, Laundry Room - EQUINT		2019	3,353	671	5	671		1,118	31
32	Ironer Repair, Laundry Room - EQUINT		2019	4,899	980	5	980		1,225	32
33										33
34	Adj for ABC related party profit		2018	41	2		2		5	34
35	Adj for ABC related party profit		2019	329	55		55		82	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 Estates Cts of Huntley

0054924

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		\$ 33,159,760	\$ 837,428		\$ 856,701	\$ 19,273	\$ 2,201,926	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)		\$ 33,306,753	\$ 842,124		\$ 861,397	\$ 19,273	\$ 2,297,697	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,748,233	\$ 328,496	\$ 328,496	\$	various	\$ 822,172	71
72	Current Year Purchases	78,636	1,661	1,661		various	1,661	72
73	Fully Depreciated Assets	82,696	25	25		various	82,696	73
74								74
75	TOTALS	\$ 2,909,565	\$ 330,183	\$ 330,183	\$		\$ 906,529	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)	\$ 37,934,620	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,172,307	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,191,580	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,273	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,208,028	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 Improvement - 2018	\$ 761,210	\$ 19,518	\$ 39,036	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 761,210	\$ 19,518	\$ 39,036	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 07/01/2018

Ending 06/01/2028

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

Fiscal Year Ending Annual Rent

12. 12/31/2021 \$ varies

13. 12/31/2022 \$ varies

14. 12/31/2023 \$ varies

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: \$ 162,160 Description: copy machine GL 6861 and equipment lease GL 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Auto lease-GL 6890</u>	<u>various</u>	\$ <u>#####</u>	\$ <u>28,489</u>	17
18					18
19	<u>Related party-PG 6A</u>	<u>various</u>	<u>754.57</u>	<u>9,055</u>	19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>37,543</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.

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 604,439	\$		\$ 604,439	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			180,614			180,614	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			708,645			708,645	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				822,116		822,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See PG16A	39-1, 39-3, if any				135,564	176,694		312,258	13
14	TOTAL			\$		\$ 1,629,262	\$ 998,811		\$ 2,628,073	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	604,439.16	
2.	ST	39-3	To Col 5	180,614.16	
3.					
4.	PT	39-3	To Col 5	708,645.46	
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			855,656.74	
	Manual Input from Related Party- Forum Drugs & Vaccinations			(33,540.30)	From Page 6C. Ln 39, Col 8 Drug Items
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	822,116.44	
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	135,563.65	From Page 6D, Col 8 (Except DD homes)
	Other			202,867.38	
	Manual Input: Related Party - Prism			(23,235.08)	From Page 6B/Ln 39 items, Col 8
	Manual Input: Related Party FECII - I.V.			(5,390.26)	From Page 6C/Ln 39 items for IV, Col 8
	Manual Input: Related Party FECII - Wound Care-Products Only			(224.72)	From Page 6C/Ln 39 items for Wound Care Products, Col 8
	Oxygen, from reclass worksheet (Pg 4A)			2,677.00	
13.	Col 6: Supplies Total		To Col 6	176,694.32	
13.	Total Line 13, Column 8			312,257.97	
14.	Total			2,628,073.19	

Facility Name & ID Number Alden Estates Cts of Huntley

0054924

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>34,000</u>)	1,437,289	1,437,289	3
4	Supply Inventory (priced at <u> </u>)	152,424	152,424	4
5	Short-Term Investments			5
6	Prepaid Insurance		98,039	6
7	Other Prepaid Expenses	10,295	10,295	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party/Escrows</u>	24,292	326,645	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,624,300	\$ 2,024,692	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	88,362	88,362	12
13	Land		1,501,186	13
14	Buildings, at Historical Cost		29,362,677	14
15	Leasehold Improvements, at Historical Cost	3,805,496	3,810,395	15
16	Equipment, at Historical Cost	600,442	2,657,721	16
17	Accumulated Depreciation (book methods)	(422,542)	(2,899,237)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		136,109	21
22	Other Long-Term Assets (spe <u>Financing Fees</u>)		1,324,167	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,071,758	\$ 35,981,380	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,696,057	\$ 38,006,072	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 974,079	\$ 917,748	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	542,468	542,468	28
29	Short-Term Notes Payable	25,003	399,257	29
30	Accrued Salaries Payable	408,786	408,786	30
31	Accrued Taxes Payable (excluding real estate taxes)	218,622	218,622	31
32	Accrued Real Estate Taxes(Sch.IX-B)		471,000	32
33	Accrued Interest Payable		90,226	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Exp/Ins,due to IDPA,SalesTax,Prov l</u>	3,222,599	3,222,599	36
37	<u>Due to Affiliates - Current</u>	1,046,138	1,046,138	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,437,695	\$ 7,316,845	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	708,992	708,992	39
40	Mortgage Payable		29,047,385	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates</u>	3,249,017	2,397,364	43
44	<u>Mcr Adv Fund, FICA Deferred</u>	222,105	222,105	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,180,114	\$ 32,375,846	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,617,810	\$ 39,692,690	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,921,753)	\$ (1,686,618)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,696,057	\$ 38,006,072	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,785,758)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,785,758)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(3,135,995)	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)	\$ (3,135,995)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,921,753)	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	\$ 11,800,970	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,800,970	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	138,363	6
7	Oxygen	1,654	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 140,017	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	156	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	209	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	4,587	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,952	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	257	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 257	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain On Sale, Vendor Discounts, Med Rec, Jury Duty</u>	2,860	28
28a	<u>Wellness Fee</u>	118,879	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,739	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,067,935	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,327,472	31
32	Health Care	4,435,378	32
33	General Administration	3,108,257	33
B. Capital Expense			
34	Ownership	2,613,781	34
C. Ancillary Expense			
35	Special Cost Centers	2,552,223	35
36	Provider Participation Fee	166,819	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,203,930	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,135,995)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,135,995)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 768,058	44
45	Private Pay - Net Inpatient Revenue	1,863,923	45
46	Medicare - Net Inpatient Revenue	7,856,691	46
47	Other-(specify) <u>Hospice</u>	1,312,298	47
48	Other-(specify) <u>Insur,Vets,Charity/Sales Allows</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,800,970	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 Estates Cts of Huntley

0054924

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	1,304	1,368	\$ 65,081	\$ 47.57	1
2	Assistant Director of Nursing	2,248	2,296	97,463	42.45	2
3	Registered Nurses	29,895	31,832	1,184,425	37.21	3
4	Licensed Practical Nurses	16,134	16,473	526,368	31.95	4
5	CNAs & Orderlies	64,733	67,893	1,373,022	20.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	1,920	44,135	22.99	9
10	Activity Assistants	4,370	4,592	60,855	13.25	10
11	Social Service Workers	1,600	1,681	39,767	23.66	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	76,655	36.85	13
14	Head Cook	12,408	12,480	324,297	25.99	14
15	Cook Helpers/Assistants	34,972	36,227	500,570	13.82	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	137,307	66.01	17
18	Housekeepers	14,799	15,542	267,124	17.19	18
19	Laundry	3,637	3,976	59,115	14.87	19
20	Administrator	2,072	2,080	125,422	60.30	20
21	Assistant Administrator					21
22	Other Administrative	6,392	6,770	218,331	32.25	22
23	Office Manager					23
24	Clerical	8,151	8,486	127,566	15.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,016	4,048	153,347	37.88	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	3,472	3,637	51,916	14.27	32
33	Other(specify) <u>Memory Care Staf</u>	14,031	14,771	248,072	16.80	33
34	TOTAL (lines 1 - 33)	230,312	240,230	\$ 5,680,838 *	\$ 23.65	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	\$ 2,334	1-3	35
36	Medical Director	Monthly	24,021	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	Monthly	1,440	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	36	1,998	11-3	44
45	Social Service Consultant	14	980	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	\$ 30,773		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	210	\$ 81,273	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	981	52,001	10-3	52
53	TOTAL (lines 50 - 52)	1,191	\$ 133,274		53

Alden Estates-Courts of Huntley, Inc.
 Legal Fee Support
 2020

PG 21A

Legal Fees Reported on Pg 21, Section C: \$ 55,173.00

Less: Collection, estates, & other non-allowable legal fees (7,149.00)
 listed on Pg 5, Line 22

Non-allowable legal fees, if any, deducted on (47,520.00)
 - AMS Allocated Legal Fees: GL 680600-100-003

+ Add Back voided invoice of prior year, if any

Allowable Legal Fees \$ 504.00

In Detail:

Vendor Name	Invoice Date	Amount
Midcap	04/20, 06/20, 07/20, 10/20	504.26
TOTAL ALLOWABLE LEGAL FEES		<u>504.26</u>

Vendor Name	Invoice Date	Amount
Stone, Poggrund & Korey LLC	01/20-12/20	7,148.86
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		<u>7,148.86</u>

Vendor Name	Invoice Date	Amount
AMS Corp Legal Cost Alloc-'20	01/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	02/28/20	3,960.00
AMS Corp Legal Cost Alloc-'20	03/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	04/30/20	3,960.00
AMS Corp Legal Cost Alloc-'20	05/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	06/30/20	3,960.00
AMS Corp Legal Cost Alloc-'20	07/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	08/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	09/30/20	3,960.00
AMS Corp Legal Cost Alloc-'20	10/31/20	3,960.00
AMS Corp Legal Cost Alloc-'20	11/30/20	3,960.00
AMS Corp Legal Cost Alloc-'20	12/31/20	3,960.00
TOTAL Allocated Legal Fees		<u>47,520.00</u>

Total Legal Cost 55,173.12

Facility Name & ID Number Alden Estates Cts of Huntley

0054924

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? Yes
If YES, give association name and amount. Healthcare Council of IL - \$16,320
- (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. \$ 23,343 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. \$ 166,819
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. \$ 21,603 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. \$ no
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? 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.