

		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><b>I. IDPH License ID Number:</b> <u>0050146</u></p> <p><b>Facility Name:</b> <u>Alden Estates of Skokie</u></p> <p><b>Address:</b> <u>4626 Old Orchard Rd</u> <u>Skokie</u> <u>60076</u>          Number  City  Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 676-4800</u>      <b>Fax #</b> <u>(847) 676-4860</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>01/09/09</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width: 33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input checked="" type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mark Novotny</u>      <b>Telephone Number:</b> <u>773-724-6362</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Type or Print Name) <u>Derek Smart</u></td> <td style="padding: 5px;">(Title) <u>CFO, Alden Management Services, Inc., as agent</u></td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Print Name and Title)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Firm Name &amp; Address)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Telephone) <u>773-286-3883</u></td> <td style="padding: 5px;">Fax # <u>773-286-8038</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b>      <b>Phone # (217) 782-1630</b></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 type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____														
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>															

Facility Name & ID Number Alden Estates of Skokie

# 0050146 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	56	Skilled (SNF)	56	20,496	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	56	TOTALS	56	20,496	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		1,135	4,091	5,226	8
9	SNF/PED					9
10	ICF	1,937			1,937	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,937	1,135	4,091	7,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 34.95%

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

None (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 1/8/09

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

YES  Date 1/8/09 NO

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

YES  NO  If YES, enter number of beds certified 56 and days of care provided 4,043

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCURAL  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 of Skokie # 0050146 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
	<b>A. General Services</b>										
1	Dietary	393,084	8,168	239	401,491	2,330	403,821	774	404,595		1
2	Food Purchase		78,332		78,332	(7,198)	71,134	552	71,686		2
3	Housekeeping	126,452	27,729		154,181	2,073	156,254	2,499	158,753		3
4	Laundry	29,288	7,644		36,931		36,931		36,931		4
5	Heat and Other Utilities			92,185	92,185		92,185	(792)	91,393		5
6	Maintenance	61,586		141,357	202,942		202,942	11,450	214,392		6
7	Other (specify):* security			1,020	1,020		1,020	1,157	2,177		7
8	<b>TOTAL General Services</b>	<b>610,410</b>	<b>121,872</b>	<b>234,800</b>	<b>967,082</b>	<b>(2,795)</b>	<b>964,287</b>	<b>15,640</b>	<b>979,927</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,079,790	117,986	2,449	1,200,225	3,955	1,204,180	12,178	1,216,358		10
10a	Therapy		463		463		463		463		10a
11	Activities	46,500	751	2,629	49,880		49,880		49,880		11
12	Social Services	48,552			48,552		48,552		48,552		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							997	997		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,174,841</b>	<b>119,201</b>	<b>14,078</b>	<b>1,308,119</b>	<b>3,955</b>	<b>1,312,074</b>	<b>13,175</b>	<b>1,325,250</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	96,133			96,133		96,133	30,606	126,739		17
18	Directors Fees										18
19	Professional Services			243,859	243,859		243,859	(174,782)	69,077		19
20	Dues, Fees, Subscriptions & Promotions			133,227	133,227		133,227	(116,169)	17,058		20
21	Clerical & General Office Expenses	88,880	5,508	129,913	224,301	(4,233)	220,068	16,655	236,723		21
22	Employee Benefits & Payroll Taxes			356,783	356,783	1,195	357,978	(2,221)	355,757		22
23	Inservice Training & Education										23
24	Travel and Seminar			930	930		930	153	1,083		24
25	Other Admin. Staff Transportation			193	193		193	1,364	1,557		25
26	Insurance-Prop.Liab.Malpractice			154,534	154,534		154,534	8,806	163,340		26
27	Other (specify):* related party			62,344	62,344		62,344	(50,223)	12,121		27
28	<b>TOTAL General Administration</b>	<b>185,013</b>	<b>5,508</b>	<b>1,081,783</b>	<b>1,272,304</b>	<b>(3,038)</b>	<b>1,269,266</b>	<b>(285,811)</b>	<b>983,455</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,970,263</b>	<b>246,581</b>	<b>1,330,661</b>	<b>3,547,505</b>	<b>(1,878)</b>	<b>3,545,627</b>	<b>(256,996)</b>	<b>3,288,632</b>		<b>29</b>

\*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			34,500	34,500		34,500	198,439	232,939			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			262	262		262	391,740	392,002			32
33	Real Estate Taxes			61,469	61,469	(61,469)		62,498	62,498			33
34	Rent-Facility & Grounds			714,255	714,255	61,469	775,724	(775,724)				34
35	Rent-Equipment & Vehicles			16,912	16,912		16,912	5,473	22,385			35
36	Other (specify):* MIP							46,020	46,020			36
37	<b>TOTAL Ownership</b>			827,399	827,399		827,399	(71,555)	755,844			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		384,620	614,365	998,985	1,878	1,000,863	(48,426)	952,437			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,590	48,590		48,590		48,590			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		384,620	662,955	1,047,575	1,878	1,049,453	(48,426)	1,001,027			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,970,263	631,201	2,821,014	5,422,479		5,422,479	(376,976)	5,045,502			45

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

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

IDPH License No. 0050146

Reclassifications - Pages 3 & 4 (Column 5)

From Line	To Line	Amount	Description
2		(7,198.00)	Employee Meals
	22	7,198.00	Employee Meals
22		(6,003.00)	Uniform Reclass
	1	2,330.00	Uniform Reclass
	3	2,073.00	Uniform Reclass
	4	-	Uniform Reclass
	6	-	Uniform Reclass
	10	1,213.00	Uniform Reclass
	11	-	Uniform Reclass
	21	387.00	Uniform Reclass
10		(1,878.00)	Oxygen Cost Reclass
	39	1,878.00	Oxygen Cost Reclass
21		(4,620.00)	Team TSI expense Reclass
	10	4,620.00	Team TSI expense Reclass
33		(61,469.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	61,469.00	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 Estates of Skokie

# 0050146

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	(48)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,124)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(107)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,069)	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		21		17
18	Fines and Penalties		32		18
19	Entertainment	(248)	20		19
20	Contributions	(2,251)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,845)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,344)	27		24
25	Fund Raising, Advertising and Promotional	(113,312)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (195,349)		\$	30

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)	(151,610)		34
35	Other- Attach Schedule	(30,017)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (181,627)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (376,976)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Alden Estates of Skokie

ID# 0050146

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (744)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(7,122)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	2,070	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	8,841	6	4
5	Reconcile depreciation expense	(317)	30	5
6	Elim ABC Deprec Exp from Pg 12 series	(1)	30	6
7	Valet cost	(12,000)	21	7
8	Late fees on utilities	(1,307)	5	8
9	Vendor Discounts	(488)	10	9
10				10
11	Back out R/E Tax Refund		33	11
12	Misc Income- Jury Duty		21	12
13	Misc. income - Record Copies	(371)	21	13
14	Misc. income - Donations		21	14
15	Back out Landowner Bank Charges	(111)	20	15
16	Chamber of Commerce fees	(615)	20	16
17	Rotary Club Fees		20	17
18	AMS Depreciation Adj.		30	18
19	Elim LI-ADG Deprec Exp	(17,852)	30	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(30,017)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Estates of Skokie

# 0050146

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	774	0	0	0	0	0	0	0	774	1
2	Food Purchase	(2,117)	0	0	2,669	0	0	0	0	0	0	0	552	2
3	Housekeeping	0	0	2,499	0	0	0	0	0	0	0	0	2,499	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,307)	0	515	0	0	0	0	0	0	0	0	(792)	5
6	Maintenance	6,787	0	4,387	0	0	0	36	240	0	0	0	11,450	6
7	Other (specify):*	0	0	1,157	0	0	0	0	0	0	0	0	1,157	7
8	<b>TOTAL General Services</b>	<b>3,363</b>	<b>0</b>	<b>8,558</b>	<b>3,443</b>	<b>0</b>	<b>0</b>	<b>36</b>	<b>240</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15,640</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(488)	0	6,780	6,488	(601)	0	0	0	0	0	0	12,178	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	997	0	0	0	0	0	0	0	0	997	15
16	<b>TOTAL Health Care and Programs</b>	<b>(488)</b>	<b>0</b>	<b>7,777</b>	<b>6,488</b>	<b>(601)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,175</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	30,606	0	0	0	0	0	0	0	0	30,606	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,845)	28,608	(192,545)	0	0	0	0	0	0	0	0	(174,782)	19
20	Fees, Subscriptions & Promotions	(116,538)	188	181	0	0	0	0	0	0	0	0	(116,169)	20
21	Clerical & General Office Expenses	(12,371)	0	29,026	0	0	0	0	0	0	0	0	16,655	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(2,221)	0	0	0	0	0	0	(2,221)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	153	0	0	0	0	0	0	0	0	153	24
25	Other Admin. Staff Transportation	0	0	1,364	0	0	0	0	0	0	0	0	1,364	25
26	Insurance-Prop.Liab.Malpractice	0	8,756	50	0	0	0	0	0	0	0	0	8,806	26
27	Other (specify):*	(62,344)	0	12,121	0	0	0	0	0	0	0	0	(50,223)	27
28	<b>TOTAL General Administration</b>	<b>(202,098)</b>	<b>37,552</b>	<b>(119,044)</b>	<b>0</b>	<b>(2,221)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(285,811)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(199,223)</b>	<b>37,552</b>	<b>(102,709)</b>	<b>9,931</b>	<b>(2,822)</b>	<b>0</b>	<b>36</b>	<b>240</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(256,996)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Estates of Skokie

# 0050146

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)	
	<b>D. Ownership</b>													
30	Depreciation	(26,036)	213,357	11,118	0	0	0	0	0	0	0	0	198,439	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(107)	390,638	1,209	0	0	0	0	0	0	0	0	391,740	32
33	Real Estate Taxes	0	61,469	1,029	0	0	0	0	0	0	0	0	62,498	33
34	Rent-Facility & Grounds	0	(775,724)	0	0	0	0	0	0	0	0	0	(775,724)	34
35	Rent-Equipment & Vehicles	0	0	5,473	0	0	0	0	0	0	0	0	5,473	35
36	Other (specify):*	0	46,020	0	0	0	0	0	0	0	0	0	46,020	36
37	<b>TOTAL Ownership</b>	<b>(26,143)</b>	<b>(64,241)</b>	<b>18,829</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(71,555)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(24,837)	(14,195)	(9,394)	0	0	0	0	0	(48,426)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(24,837)</b>	<b>(14,195)</b>	<b>(9,394)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48,426)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(225,366)	(26,689)	(83,880)	(14,906)	(17,017)	(9,394)	36	240	0	0	0	(376,976)	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 Rental Income	\$ 775,724	Alden Estates of Skokie, LLC	0.00%	\$	\$ (775,724)	1
2	V	32 Interest Income Repl Reserve	143	Alden Estates of Skokie, LLC			(143)	2
3	V	19 Accounting/Professional fees		Alden Estates of Skokie, LLC		15,274	15,274	3
4	V	19 Legal Fees:Non-collections		Alden Estates of Skokie, LLC		13,334	13,334	4
5	V	20 Licen&Inspect/Annual Rep		Alden Estates of Skokie, LLC		188	188	5
6	V	6 R & M		Alden Estates of Skokie, LLC				6
7	V	33 Real Estate Tax Expense		Alden Estates of Skokie, LLC		61,469	61,469	7
8	V	26 General Insurance Expense		Alden Estates of Skokie, LLC		8,756	8,756	8
9	V	36 Mortgage Insurance Premium		Alden Estates of Skokie, LLC		46,020	46,020	9
10	V	32 Interest on Mortgage		Alden Estates of Skokie, LLC		386,437	386,437	10
11	V	30 Depreciation		Alden Estates of Skokie, LLC		213,357	213,357	11
12	V	32 Amortization		Alden Estates of Skokie, LLC		4,344	4,344	12
13	V	21 Write OFF Old A/P		Alden Estates of Skokie, LLC				13
14	Total		\$ 775,867			\$ 749,178	\$ * (26,689)	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%	\$ 515	\$	515	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		153		153	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,364		1,364	17
18	V	26 Insurance		Alden Management Services, Inc.		50		50	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		181		181	19
20	V	30 Depreciation		Alden Management Services, Inc.		11,118		11,118	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		1,029		1,029	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		5,473		5,473	22
23	V	32 Interest		Alden Management Services, Inc.		1,209		1,209	23
24	V	1 Dietary		Alden Management Services, Inc.					24
25	V	3 Houskeeping		Alden Management Services, Inc.		2,499		2,499	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		1,157		1,157	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		6,780		6,780	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		997		997	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		30,606		30,606	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		12,121		12,121	30
31	V	19 Professional Fees	213,382	Alden Management Services, Inc.		20,837		(192,545)	31
32	V	21 General & Administrative	21,480	Alden Management Services, Inc.		50,506		29,026	32
33	V	6 Repairs & Maintenance	10,160	Alden Management Services, Inc.		14,547		4,387	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 245,022			\$ 161,142	\$ *	(83,880)	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.	\$	Prism Health Care Services, Inc.	0.00%	\$	\$	15
16	V	1 Dietary Salary		Prism Health Care Services, Inc.				16
17	V	2 Tube feeding	20	Prism Health Care Services, Inc.		331	311	17
18	V	10 Equip. Rental	6,660	Prism Health Care Services, Inc.		12,452	5,792	18
19	V	39 Ancillary supplies	41,380	Prism Health Care Services, Inc.		12,261	(29,119)	19
20	V	1 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		774	774	20
21	V	2 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		2,358	2,358	21
22	V	10 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		696	696	22
23	V	39 Gen'l & Admin & benefits		Prism Health Care Services, Inc.		4,282	4,282	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		\$ 48,060			\$ 33,154	\$ * (14,906)	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	\$ 290,248	Forum Extended Care II, Inc.	0.00%	\$ 276,456	\$ (13,792)
16	V	39 I.V.	52,841	Forum Extended Care II, Inc.		50,330	(2,511)
17	V	39 Wound Care-Product only	150	Forum Extended Care II, Inc.		143	(7)
18	V	10 House Stock	11,313	Forum Extended Care II, Inc.		10,776	(538)
19	V	10 Pharm Consult	1,344	Forum Extended Care II, Inc.		1,280	(64)
20	V	22 Employee Vaccinations	2,221	Forum Extended Care II, Inc.			(2,221)
21	V	39 Employee Vaccinations		Forum Extended Care II, Inc.		2,115	2,115
22	V						
23	V						
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		\$ 358,118			\$ 341,100	\$ * (17,017)

\* 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	\$ 585,218	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 575,825	\$ (9,394)	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		\$ 585,218			\$ 575,825	\$ * (9,394)	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	\$ 15,248	Alden Bennett Construction Company, Inc.	0.00%	\$ 15,284	\$	36	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		\$ 15,248			\$ 15,284	\$ *	36	39

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

Facility Name & ID Number

Alden Estates of Skokie

# 0050146

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	\$ 260	Alden Design Group, Ltd.	0.00%	\$ 500	\$ 240	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		\$ 260			\$ 500	\$ *	240	39

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



Facility Name &amp; ID Number

Alden Estates of Skokie

# 0050146

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 Care Center	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Care Center	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care Center	Chicago	FECS of Central Illinois	Springfield	Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomington	Alden Management Services	Chicago	Management	5
6			Alden Terrace of McHenry Rehabilitation and Health Care Center	McHenry				6
7			Wentworth Rehabilitation and Health Care Center	Chicago	Alden Garden Courts of	DesPlaines	Assisted Living/Alzheimer's	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	SNF & Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health Care Center	Bloomington	Alden Gardens of Water	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Youth	Bloomington	Prism Health Care Services	Schaumburg	Nursing and Durables	10
11			Alden - Orland Park Rehabilitation and Health Care Center	Orland Park	Community Physical Therapy	Addison	Therapy Provider	11
12			Princeton Rehabilitation and Health Care Center	Chicago	Alden Bennett Construction	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomington	Fort Medical Equipment	Fort Atkinson	Nursing and Durables	13
14			Alden - Town Manor Rehabilitation and Health Care Center	Cicero	Alden Design Group, Inc.	Chicago	Design & Engineering	14
15			Alden Trails, Inc.	Bloomington				15
16			Alden - Poplar Creek Rehabilitation and Health Care Center	Hoffman Estates	Family Solutions for Services	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health Care Center	Skokie	Family Home Health Services	Addison	Home health & hospice	17
18			Alden - Des Plaines Rehabilitation and Health Care Center	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 Shorewood	Shorewood	SNF	26
27			Alden Estates of Skokie, Inc.	Skokie	Alden Estates-Courts of	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 Care Center	Long Grove				30

Facility Name & ID Number Alden Estates of Skokie # 0050146 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	183,904	0.236	0.59	Salary	\$ 1,096	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,408	0.236	0.59	Salary	592	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,408	0.236	0.59	Salary	592	6-7	3
4	Ina Schlossberg D.	Board Member	Board Member	0.00	113,137	0.236	0.59	Salary	674	17-7	4
5	Audra Elisco F.	Medical Records Cle	Medical records	0.00	63,067	0.236	0.59	Salary	376	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	183,904	0.2065	0.59	Salary	1,096	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	\$ 4,427		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 of Skokie

# 0050146 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

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

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773-286-3883  
 Fax Number ( 773-286-8038

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	1,209,117	36	\$ 86,976	\$ 7,163	\$ 515	1	
2	24	Trav & Seminar	Patient Days	1,209,117	36	25,753	7,163	153	2	
3	25	Other Admin Travel	Patient Days	1,209,117	36	230,320	7,163	1,364	3	
4	26	Insurance	Patient Days	1,209,117	36	8,433	7,163	50	4	
5	20	Dues & Subscriptions	Patient Days	1,209,117	36	30,557	7,163	181	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	7,163	1,029	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,209,117	36	923,790	7,163	5,473	8	
9	32	Interest	Patient Days/usage	1,209,117	36	1,567,343	7,163	1,209	9	
10	3	Housekeeping Salary	Patient Days	1,209,117	36	421,760	421,760	7,163	2,499	10
11	7	Employee Benefits -Gen'I Servs	Patient Days	1,209,117	36	195,292	7,163	1,157	11	
12	10	Nurs & Med Records Salary	Patient Days	1,209,117	36	1,149,694	1,149,694	7,163	6,780	12
13	15	Employee Benefits -Health Care	Patient Days	1,209,117	36	168,303	7,163	997	13	
14	17	Administrative Salary	Patient Days/usage	1,209,117	36	5,264,790	5,264,790	7,163	30,606	14
15	27	Employee Benefits - Admin	Patient Days	1,209,117	36	2,046,057	7,163	12,121	15	
16	19	Professional fees	Patient Days	1,209,117	36	1,372,458	1,094,350	7,163	20,837	16
17	21	Gen'I & Admin	Patient Days	1,209,117	36	8,525,354	7,617,708	7,163	50,506	17
18	6	Repair & Maint.	Patient Days	1,209,117	36	1,379,344	912,301	7,163	14,547	18
19					36				19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 24,005,407	\$ 16,460,603	\$ 161,142	25	

Facility Name & ID Number

Alden Estates of Skokie

# 0050146

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cambridge Realty		x	Mortgage	\$33,994.47	10/13	\$ 9,024,300	\$ 8,320,361	7/51	2.8500	\$ 386,437	1								
2												2								
3												3								
4	Insurance Interest (GL7053)		x	Medical Malpractice								52	4							
5	Amort of Fin Fees (GL 1918)		x	Refinancing								4,344	5							
<b>Working Capital</b>																				
6	Related party - AMS		x	Working capital								1,209	6							
7													7							
8	Ascentium (GL 7030)		x	Capital Lease								210	8							
9	<b>TOTAL Facility Related</b>				\$33,994.47		\$ 9,024,300	\$ 8,320,361			\$ 392,252	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income on R.R.		x									(143)	10							
11	Interest Income (GL 4975)		x									(107)	11							
12													12							
13													13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (250)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,024,300	\$ 8,320,361			\$ 392,002	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46,020 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.	\$	388,900	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.)	\$	221,869	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(167,031)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	228,500	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	61,469	7
Real Estate Tax History:	\$	1,029	
	\$	62,498	

  

Real Estate Tax Bill for Calendar Year:	2015	103,290	8	
	2016	102,571	9	
	2017	107,283	10	
	2018	106,512	11	
	2019	221,869	12	

  

<b>The current year accrual is based on an estimated 3% increase of the prior year tax.</b>			
	<b>FOR BHF USE ONLY</b>		
	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 Estates of Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050146

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>1,029.00</u>
2. <u>10-10-103-032</u>	<u>Nursing Home Facility</u>	\$ <u>221,869.05</u>	\$ <u>221,869.05</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>395,565.05</u></u>	\$ <u><u>222,898.05</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.**

Facility Name & ID Number Alden Estates of Skokie

# 0050146

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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>2009</u>	<u>\$ 229,315</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 229,315</b>	<b>3</b>

**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	56	2009		\$ 1,231,396	\$ 31,574	39	\$ 31,574	\$	\$ 378,889
5			2011	6,157,997	157,897	39	157,897		1,526,338
6									
7									
8									
<b>Improvement Type**</b>									
9	GT Mechanical-Actuator, Transformer, Belts, & Filters (HVAC)		2009	2,838		5			2,838
10	Long Elevator - Elevator Pump Motor		2009	3,139		5			3,139
11									
12	Gutters and Downspouts installation-ABC		2011	8,173	817	10	817		7,557
13	Sprinkler system installation-ABC		2011	5,662	226	25	226		2,131
14	Heating system for roof-ABC		2011	48,105	4,811	10	4,811		43,700
15	Design & permit of alternate water service-JACHEF		2011	2,928	293	10	293		2,832
16	Design & permit of alternate water service-JACHEF		2011	2,867	287	10	287		2,750
17									
18									
19									
20	Tuck pointed chimney, cap replaced-ALDBEN		2012	3,207	214	15	214		1,730
21									
22	Motor-Inducer & Fuses On HVAC unit - GT Mechanical		2013	4,843		5			4,843
23									
24	Replace damaged skylights-Alden Bennett		2014	6,381	1	5	1		6,381
25									
26	Sub ceilings for elev and stairwell -ALDBEN		2015	11,442	458	25	458		2,709
27	Walkway Brick Pavers installed-SEBLAN		2015	7,180	479	15	479		2,595
28									
29	Motor, for Washer -EQUINT		2017	2,776	555	5	555		1,711
30	Repair Pavers -Outdoors- SEBLAN		2019	4,928	986	5	986		1,150
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total



## XI. OWNERSHIP COSTS (continued)

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

1	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	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,503,862	\$ 198,598		\$ 198,598	\$	\$ 1,991,293	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,650,855	\$ 203,294		\$ 203,294	\$	\$ 2,087,064	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,650,855	\$ 203,294		\$ 203,294	\$	\$ 2,087,064	1
2	Adj for ABC related party profit	2011	605					605	2
3	Adj for ABC related party profit	2012	198	1		1		198	3
4	Adj for ABC related party profit	2014	(12)	(1)		(1)		(4)	4
5	Adj for ABC related party profit	2015	(22)	(1)		(1)		(4)	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,651,624	\$ 203,293		\$ 203,293	\$	\$ 2,087,859	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	\$ 292,379	\$ 27,651	\$ 27,651	\$	various	\$ 144,914	71
72	Current Year Purchases	51,798	1,257	1,257		various	1,257	72
73	Fully Depreciated Assets	903,127	737	737		various	903,127	73
74								74
75	TOTALS	\$ 1,247,303	\$ 29,646	\$ 29,646	\$		\$ 1,049,299	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)	\$ 9,132,045	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 232,939	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,939	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,140,960	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-ADG-2018	\$ 696,222	\$ 17,852	\$ 35,704	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 696,222	\$ 17,852	\$ 35,704	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 01/01/09

Ending 12/31/21

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

Fiscal Year Ending Annual Rent

12. 12/31/2021 \$ varies

13. \$

14. \$

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: \$ 19,895 Description: Copy machine \$16,912.41 and equipment lease \$2,982.92

(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>212.18</u>	\$ <u>2,546</u>	17
18					18
19	<u>Auto lease-GL 6890</u>		<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>212.18</u>	\$ <u>2,546</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39-3	hrs					\$ 154,039							\$ 154,039	1
2	Licensed Speech and Language Development Therapist	39-3	hrs					9,085							9,085	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs					422,824							422,824	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							278,571					278,571	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						(9,394)		97,311					87,917	13
14	TOTAL				\$			\$ 576,554		\$ 375,883				\$	952,437	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	154,038.50	
2.	ST	39-3	To Col 5	9,085.16	
3.					
4.	PT	39-3	To Col 5	422,824.35	
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			290,248.49	
	Manual Input from Related Party- Forum Drugs & Vaccinations			(11,677.06)	From Page 6C. Ln 39, Col 8 Drug Items
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	278,571.43	
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	(9,393.82)	From Page 6D, Col 8 (Except DD homes)
	Other			122,788.00	
	Manual Input: Related Party - Prism			(24,836.75)	From Page 6B/Ln 39 items, Col 8
	Manual Input: Related Party FECII - I.V.			(2,510.98)	From Page 6C/Ln 39 items for IV, Col 8
	Manual Input: Related Party FECII - Wound Care-Products Only			(7.11)	From Page 6C/Ln 39 items for Wound Care Products, Col 8
	Oxygen, from reclass worksheet (Pg 4A)			1,878.00	
13.	Col 6: Supplies Total		To Col 6	97,311.16	
13.	Total Line 13, Column 8			87,917.34	
14.	Total			952,436.78	

Facility Name & ID Number Alden Estates of Skokie  
 XV. BALANCE SHEET - Unrestricted Operating Fund.

# 0050146  
 As of 12/31/2020

Report Period Beginning: 01/01/2020  
 (last day of reporting year)

Ending: 12/31/2020

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (9,500) )	345,854	345,854	3
4	Supply Inventory (priced at )	53,647	53,647	4
5	Short-Term Investments			5
6	Prepaid Insurance		43,360	6
7	Other Prepaid Expenses	7,969	7,969	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>	10,392	126,965	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 417,863	\$ 577,795	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,550	4,550	12
13	Land		373,915	13
14	Buildings, at Historical Cost		7,395,188	14
15	Leasehold Improvements, at Historical Cost	762,132	762,132	15
16	Equipment, at Historical Cost	197,161	1,246,835	16
17	Accumulated Depreciation (book methods)	(217,123)	(3,053,903)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		542,331	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Refinancing fees</u>		77,287	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 746,721	\$ 7,348,336	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,164,583	\$ 7,926,131	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 297,788	\$ 273,615	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,403	18,403	28
29	Short-Term Notes Payable	1,743	174,796	29
30	Accrued Salaries Payable	200,397	200,397	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,835	64,835	31
32	Accrued Real Estate Taxes(Sch.IX-B)		228,500	32
33	Accrued Interest Payable		19,761	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accr Exp/Ins,d/t PA,SaleTx,Prov Rel, CM</u>	1,450,073	1,450,073	36
37	<u>Due to Affiliates</u>	388,390	388,390	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,421,630	\$ 2,818,770	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	335,720	335,720	39
40	Mortgage Payable		8,147,309	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Due to Affiliates</u>	8,242,428	7,914,498	43
44	<u>Mcr Adv Fund &amp; Fica-Deferred</u>	500,762	500,762	44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 9,078,910	\$ 16,898,288	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 11,500,540	\$ 19,717,058	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (10,335,957)	\$ (11,790,927)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,164,583	\$ 7,926,131	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,543,934)	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded		3
4	after prior year report submitted:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,543,934)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,792,023)	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)	\$ (1,792,023)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (10,335,957)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,603,256	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,603,256	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	21,317	6
7	Oxygen	3,310	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 24,627	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	285	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	48	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	290	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 623	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	107	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 107	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See PG 19A	1,844	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,844	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,630,456	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	967,082	31
32	Health Care	1,308,119	32
33	General Administration	1,272,304	33
<b>B. Capital Expense</b>			
34	Ownership	827,399	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	998,985	35
36	Provider Participation Fee	48,590	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,422,479	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,792,023)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,792,023)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 449,972	44
45	Private Pay - Net Inpatient Revenue	45,445	45
46	Medicare - Net Inpatient Revenue	2,599,791	46
47	Other-(specify) Hospice / Insurance	511,604	47
48	Other-(specify) Vets,Charity/Sales Allows	(3,556)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,603,256	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 &amp; ID Number

Alden Estates of Skokie

# 0050146

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

**Details of Page 19, Line 28**

<u>Description</u>	<u>Amount</u>
Misc. Income GL#4977 (describe) (is offset against Sch.# V)	
Record Copies-Backed out with Ln ref 21-Pg 5A	371
Jury Duty-Backed out with Ln ref 22-Pg 5A	
Donation-Backed out with Ln ref 21-Pg 5A	
Settlements-Backed out with Ln ref 21-Pg 5A	
Write Off Old Accounts Payables	
Vendor Discount	488
United Healthcare-(Rebate/Incentive)	
Gain on Sale of Assets (related to prior yr, not offset on Sch.# V)	985
Line 28 Total:	<u><u>1,844</u></u>

Facility Name & ID Number Alden Estates of Skokie

# 0050146

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	2,056	2,080	\$ 141,487	\$ 68.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,021	14,012	482,094	34.41	3
4	Licensed Practical Nurses	2,736	3,117	95,442	30.62	4
5	CNAs & Orderlies	16,529	18,020	294,100	16.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,973	3,320	46,500	14.01	10
11	Social Service Workers	2,132	2,148	48,552	22.61	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,080	50,055	24.06	13
14	Head Cook	4,224	4,456	94,862	21.29	14
15	Cook Helpers/Assistants	15,715	17,364	248,168	14.29	15
16	Dishwashers					16
17	Maintenance Workers	2,056	2,080	61,586	29.61	17
18	Housekeepers	8,101	8,799	126,452	14.37	18
19	Laundry	1,914	2,023	29,288	14.48	19
20	Administrator	2,072	2,080	96,133	46.22	20
21	Assistant Administrator					21
22	Other Administrative	1,618	1,682	40,517	24.09	22
23	Office Manager					23
24	Clerical	3,204	3,516	48,363	13.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,743	1,751	66,667	38.08	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	82,141	88,528	\$ 1,970,263 *	\$ 22.26	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	20/mo	\$ 239	1-3	35
36	Medical Director	750/mo	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	112/mo	1,344	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	7	389	11-3	44
45	Social Service Consultant	187/mo	2,240	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7	\$ 13,212		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2	\$ 387	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2	\$ 387		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				
EFFERT, ALEXIS	Administrator	0	\$ 96,133	Workers' Compensation Insurance	\$ 63,279	IDPH License Fee	\$				
		0		Unemployment Compensation Insurance	7,529	Advertising: Employee Recruitment	2,238				
		0		FICA Taxes	143,624	Health Care Worker Background Check					
		0		Employee Health Insurance	110,911	(Indicate # of checks performed 8)	271				
		0		Employee Meals	7,198	Patient Background Checks	2,660				
		0		Illinois Municipal Retirement Fund (IMRF)*		HEACOU dues	5,376				
		0		Dental Insurance	(20)	NY Times/USA Today/Chi Trib/Music	5,575				
				Life Insurance/Vision Insurance	1,359	Surety Bond/Annual Rpt Fee	253				
				Employee Relations/Misc costs	10,436	Collab Health/American Healthcare	504				
				Employee drug tests	9,137	Related Party - AMS	181				
				401K Match/Employee vaccinations	4,524	Less: Public Relations Expense	( )				
				Related Party Forum	(2,220)	Non-allowable advertising	( )				
				Tuition Reimbursement		Yellow page advertising	( )				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)				TOTAL (agree to Sch. V, line 20, col. 8)			
\$ 96,133				\$ 355,757				\$ 17,058			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount			
			\$			\$	Out-of-State Travel	\$			
							In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				TOTAL (agree to Sch. V, line 24, col. 8)			
\$				\$				\$ 1,083			
C. Professional Services											
Vendor/Payee	Type	Amount									
Alden Management Services	Consulting Fees	\$	188,248								
Baker Tilly, LLP	Accounting Fees		7,281								
C. Novotny/Int'l Micro Des.	Accounting Fees		190								
ACHACC Achieve Accred.	Consulting		7,127								
AMS (Eliminated)	Allocated Legal Services		25,200								
Stone Pogrund & Korey	Legal - collections		8,390								
SB2 Inc	Legal - collections		2,455								
Baker Tilly, LLP	Professional Fees		187					Related Party - AMS 153			
Ives/Ryan	Photography/Plans		4,780					Seminar Expense			
								NIC National Conference 268			
								WHCA-WiCAL Convention 639			
								Senior Lifestyle Expo 23			
								Entertainment Expense ( )			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 243,859							

\* Attach copy of IMRF notifications

\*\*See instructions.

Alden Estates of Skokie  
 Legal Fee Support  
 2020

PG 21A

Legal Fees Reported on Pg 21, Section C:	\$ 36,045.08
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22	(10,845.08)
Non-allowable legal fees, if any, deducted on	
- AMS Allocated Legal Fees: GL 680600-100-003	(25,200.00)
+ Add Back voided invoice of prior year, if any	
Allowable Legal Fees	<u>\$ -</u>

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
<b>TOTAL ALLOWABLE LEGAL FEES</b>		<u>-</u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
<b>Stone Poggrund &amp; Korey</b>	1/1/2020-12/31/2020	8,390.48
<b>SB2 Inc</b>	1/1/2020-12/31/2020	2,454.60

**TOTAL Collection-NOT ALLOWABLE LEGAL FEES** 10,845.08

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
<b>AMS Legal Allocation</b>	Monthly Legal Work	25,200.00

**TOTAL Allocated Legal Fees** 25,200.00

Total Legal Cost 36,045.08

Facility Name &amp; ID Number Alden Estates of Skokie

# 0050146

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. Health Care Council of IL \$5,376
- (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. \$ 2,396 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. \$ 48,590  
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. \$ 7,198 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.