

		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>0042051</u></p> <p>Facility Name: <u>Alden Trails</u></p> <p>Address: <u>273 Army Trail Road</u> <u>Bloomington</u> <u>60108</u> <small>Number City Zip Code</small></p> <p>County: <u>Dupage</u></p> <p>Telephone Number: <u>(630) 671-1990</u> Fax # <u>(630) 671-0540</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/19/98</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input checked="" type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mark Novotny</u> Telephone Number: <u>773-724-6362</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Derek Smart</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>CFO, Alden Management Services, Inc., as agent</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u></td> </tr> </table> <p align="right">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 Trails

0042051 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		Skilled (SNF)		0	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	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,458			5,458	13
14	TOTALS	5,458			5,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.20%

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

30 (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 8/15/98

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 _____ and days of care provided _____

Medicare Intermediary N/A

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 Trails # 0042051 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	80,380	4,911	4,909	90,200	719	90,919	(1,703)	89,216		1
2	Food Purchase		55,221		55,221	(8,789)	46,432	(2,787)	43,645		2
3	Housekeeping	12,603	10,674		23,277		23,277	1,904	25,181		3
4	Laundry		6,180		6,180		6,180		6,180		4
5	Heat and Other Utilities			15,737	15,737		15,737	265	16,002		5
6	Maintenance			48,544	48,544		48,544	10,572	59,116		6
7	Other (specify):* related party / Security			514	514		514	882	1,396		7
8	TOTAL General Services	92,983	76,986	69,704	239,673	(8,070)	231,603	9,133	240,736		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	628,140	57,719	384	686,243	551	686,794	5,748	692,542		10
10a	Therapy			5,741	5,741		5,741	1,395	7,136		10a
11	Activities	42,475	28	1,489	43,992		43,992		43,992		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							760	760		15
16	TOTAL Health Care and Programs	670,615	57,747	11,214	739,576	551	740,127	7,903	748,030		16
	C. General Administration										
17	Administrative							23,321	23,321		17
18	Directors Fees										18
19	Professional Services			106,352	106,352		106,352	(77,039)	29,313		19
20	Dues, Fees, Subscriptions & Promotions			2,726	2,726		2,726	(774)	1,952		20
21	Clerical & General Office Expenses	51,996	1,161	28,706	81,863		81,863	31,170	113,033		21
22	Employee Benefits & Payroll Taxes			154,505	154,505	7,485	161,990	(202)	161,788		22
23	Inservice Training & Education										23
24	Travel and Seminar			216	216		216	116	332		24
25	Other Admin. Staff Transportation			742	742		742	1,040	1,782		25
26	Insurance-Prop.Liab.Malpractice			44,153	44,153		44,153	1,757	45,910		26
27	Other (specify):* related party			1,280	1,280		1,280	7,966	9,246		27
28	TOTAL General Administration	51,996	1,161	338,680	391,837	7,485	399,322	(12,645)	386,677		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	815,594	135,894	419,598	1,371,086	(34)	1,371,052	4,391	1,375,443		29

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

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

Facility Name & ID Number Alden Trails

#0042051

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			6,920	6,920		6,920	38,787	45,707			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,786	5,786		5,786	28,229	34,015			32
33	Real Estate Taxes			17,744	17,744	(17,744)		20,411	20,411			33
34	Rent-Facility & Grounds			74,999	74,999	17,744	92,743	(92,743)				34
35	Rent-Equipment & Vehicles			1,480	1,480		1,480	4,170	5,650			35
36	Other (specify):* MIP							5,142	5,142			36
37	TOTAL Ownership			106,929	106,929		106,929	3,996	110,925			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,427		16,427	34	16,461	(7,373)	9,088			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,651	78,651		78,651		78,651			42
43	Other (specify):* Day Training			327,058	327,058		327,058		327,058			43
44	TOTAL Special Cost Centers		16,427	405,709	422,136	34	422,170	(7,373)	414,797			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	815,594	152,321	932,236	1,900,151		1,900,151	1,014	1,901,165			45

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

Alden Trails
 Period Beginning: 1/1/2020
 Period Ending: 12/31/2020

IDPH License No. 0042051

Reclassifications - Pages 3 & 4 (Column 5)

From Line	To Line	Amount	Description
2		(8,789.00)	Employee Meals
	22	8,789.00	Employee Meals
22		(1,304.00)	Uniform Reclass
	1	719.00	Uniform Reclass
	3		Uniform Reclass
	4		Uniform Reclass
	6		Uniform Reclass
	10	585.00	Uniform Reclass
	11		Uniform Reclass
	21		Uniform Reclass
10		(34.00)	Oxygen Cost Reclass
	39	34.00	Oxygen Cost Reclass
33		(17,744.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	17,744.00	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 Trails

0042051

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,354)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,674)	21		17
18	Fines and Penalties				18
19	Entertainment	(261)	20		19
20	Contributions	(330)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,280)	27		24
25	Fund Raising, Advertising and Promotional	(321)	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)	\$ (5,220)		\$	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)	9,591		34
35	Other- Attach Schedule	(3,357)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,234		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,014		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 Trails

ID# 0042051

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Late Fees on Utilities	(128)	5	2
3	Intercompany Interest	(5,771)	32	3
4	Elim Deprec Exp on Pg 12 items under \$2,500 -	(2,130)	30	4
5	Elim Deprec Exp on Pg 13 items under \$2500 -	(4,406)	30	5
6	Expense Pg 12 items under \$2,500 - curr yr purchs +	2,197	6	6
7	Expense Pg 13 items under \$2,500 - curr yr purchs +	6,531	6	7
8	Reconcile Depreciation Expense	288	30	8
9	Elim ABC Deprec Exp from Pg 12 Series	62	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,357)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(1,703)	0	0	0	0	0	0	0	(1,703)	1
2	Food Purchase	0	0	0	(2,787)	0	0	0	0	0	0	0	(2,787)	2
3	Housekeeping	0	0	1,904	0	0	0	0	0	0	0	0	1,904	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(128)	0	393	0	0	0	0	0	0	0	0	265	5
6	Maintenance	7,374	0	3,021	0	0	0	8	169	0	0	0	10,572	6
7	Other (specify):*	0	0	882	0	0	0	0	0	0	0	0	882	7
8	TOTAL General Services	7,246	0	6,200	(4,490)	0	0	8	169	0	0	0	9,133	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,166	715	(133)	0	0	0	0	0	0	5,748	10
10a	Therapy	0	0	0	0	0	1,395	0	0	0	0	0	1,395	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	760	0	0	0	0	0	0	0	0	760	15
16	TOTAL Health Care and Programs	0	0	5,926	715	(133)	1,395	0	0	0	0	0	7,903	16
	C. General Administration													
17	Administrative	0	0	23,321	0	0	0	0	0	0	0	0	23,321	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,050	(81,089)	0	0	0	0	0	0	0	0	(77,039)	19
20	Fees, Subscriptions & Promotions	(912)	0	138	0	0	0	0	0	0	0	0	(774)	20
21	Clerical & General Office Expenses	(1,674)	0	32,844	0	0	0	0	0	0	0	0	31,170	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(202)	0	0	0	0	0	0	(202)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	116	0	0	0	0	0	0	0	0	116	24
25	Other Admin. Staff Transportation	0	0	1,040	0	0	0	0	0	0	0	0	1,040	25
26	Insurance-Prop.Liab.Malpractice	0	1,719	38	0	0	0	0	0	0	0	0	1,757	26
27	Other (specify):*	(1,280)	10	9,236	0	0	0	0	0	0	0	0	7,966	27
28	TOTAL General Administration	(3,866)	5,779	(14,356)	0	(202)	0	0	0	0	0	0	(12,645)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	3,380	5,779	(2,230)	(3,775)	(335)	1,395	8	169	0	0	0	4,391	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Trails

0042051

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	(6,186)	33,855	11,118	0	0	0	0	0	0	0	0	38,787	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,771)	27,307	6,693	0	0	0	0	0	0	0	0	28,229	32
33	Real Estate Taxes	0	19,627	784	0	0	0	0	0	0	0	0	20,411	33
34	Rent-Facility & Grounds	0	(92,743)	0	0	0	0	0	0	0	0	0	(92,743)	34
35	Rent-Equipment & Vehicles	0	0	4,170	0	0	0	0	0	0	0	0	4,170	35
36	Other (specify):*	0	5,142	0	0	0	0	0	0	0	0	0	5,142	36
37	TOTAL Ownership	(11,957)	(6,812)	22,765	0	0	0	0	0	0	0	0	3,996	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	(7,426)	53	0	0	0	0	0	0	(7,373)	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	(7,426)	53	0	0	0	0	0	0	(7,373)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,577)	(1,033)	20,535	(11,201)	(282)	1,395	8	169	0	0	0	1,014	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	\$ 92,743	Alden of Bloomingdale Limited Partnership	0.00%	\$	\$ (92,743)	1
2	V	32 Interest Income - Rep Reserve	4	Alden of Bloomingdale Limited Partnership			(4)	2
3	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		4,050	4,050	3
4	V	19 Legal Fees: Non-Collections		Alden of Bloomingdale Limited Partnership				4
5	V	19 Professional Fees		Alden of Bloomingdale Limited Partnership				5
6	V	21 Corporate Annual Report Fees		Alden of Bloomingdale Limited Partnership				6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		19,627	19,627	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,719	1,719	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		5,142	5,142	9
10	V	32 Interest-Mortgage		Alden of Bloomingdale Limited Partnership		25,709	25,709	10
11	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		33,855	33,855	11
12	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		1,602	1,602	12
13	V	27 Income Tax Expense		Alden of Bloomingdale Limited Partnership		10	10	13
14	Total		\$ 92,747			\$ 91,714	\$ * (1,033)	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%	\$ 393	\$	393	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		116		116	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,040		1,040	17
18	V	26 Insurance		Alden Management Services, Inc.		38		38	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		138		138	19
20	V	30 Depreciation		Alden Management Services, Inc.		11,118		11,118	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		784		784	21
22	V	35 Rent-Equipment & Vehicles		Alden Management Services, Inc.		4,170		4,170	22
23	V	32 Interest		Alden Management Services, Inc.		6,693		6,693	23
24	V	3 Housekeeping		Alden Management Services, Inc.		1,904		1,904	24
25	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		882		882	25
26	V	10 Nursing & Medical Record Salaries		Alden Management Services, Inc.		5,166		5,166	26
27	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		760		760	27
28	V	17 Administrative Salary		Alden Management Services, Inc.		23,321		23,321	28
29	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		9,236		9,236	29
30	V	19 Professional Fees	101,534	Alden Management Services, Inc.		20,445		(81,089)	30
31	V	21 General & Administrative	5,640	Alden Management Services, Inc.		38,484		32,844	31
32	V	6 Repairs & Maintenance	5,726	Alden Management Services, Inc.		8,747		3,021	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 112,900			\$ 133,435	\$ *	20,535	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.	\$ 4,909	Prism Health Care Services, Inc.	0.00%	\$	\$ (4,909)	15
16	V	1 Dietary Salary				2,760	2,760	16
17	V	2 Tube feeding	8,971			4,824	(4,147)	17
18	V	10 Equip. Rental	360			673	313	18
19	V	39 Ancillary supplies	13,480			3,584	(9,896)	19
20	V	1 Gen'l & Admin & benefits				446	446	20
21	V	2 Gen'l & Admin & benefits				1,360	1,360	21
22	V	10 Gen'l & Admin & benefits				402	402	22
23	V	39 Gen'l & Admin & benefits				2,470	2,470	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		\$ 27,720			\$ 16,519	\$ * (11,201)	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	\$ 2,730	Forum Extended Care II, Inc.	0.00%	\$ 2,601	\$ (129)	15
16	V	39 I.V.		Forum Extended Care II, Inc.				16
17	V	39 Wound Care-Product only	216	Forum Extended Care II, Inc.		206	(10)	17
18	V	10 House Stock	2,426	Forum Extended Care II, Inc.		2,311	(115)	18
19	V	10 Pharm Consult	384	Forum Extended Care II, Inc.		366	(18)	19
20	V	22 Employee Vaccinations	202	Forum Extended Care II, Inc.			(202)	20
21	V	39 Employee Vaccinations		Forum Extended Care II, Inc.		192	192	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		\$ 5,958			\$ 5,676	\$ * (282)	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	10a Therapy	\$ 5,741	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 7,136	\$ 1,395	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		\$ 5,741			\$ 7,136	\$ *	1,395	39

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

Facility Name & ID Number Alden Trails

0042051

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	\$ 3,464	Alden Bennett Construction Company, Inc.	0.00%	\$ 3,472	\$	8 15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,464			\$ 3,472	\$ *	8 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	\$ 183	Alden Design Group, Ltd.	0.00%	\$ 352	\$ 169	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		\$ 183			\$ 352	\$ *	169	39

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

Facility Name & ID Number

Alden Trails

0042051

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 Trails # 0042051 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	184,165	0.18	0.45	Salary	\$ 835	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,549	0.18	0.45	Salary	451	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,549	0.18	0.45	Salary	451	6-7	3
4	Ina Schlossberg D.	Board Member	Board member	0.00	113,297	0.18	0.45	Salary	514	17-7	4
5	Audra Elisco F.	Medical Records Cle	Medical records	0.00	63,157	0.18	0.45	Salary	286	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	184,165	0.1575	0.45	Salary	835	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	\$ 3,372		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 Trails

0042051

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	\$ 5,458	\$ 393	1	
2	24	Travel & Seminar	Patient Days	1,209,117	36	25,753	5,458	116	2	
3	25	Other Admin Travel	Patient Days	1,209,117	36	230,320	5,458	1,040	3	
4	26	Insurance	Patient Days	1,209,117	36	8,433	5,458	38	4	
5	20	Dues & Subscriptions	Patient Days	1,209,117	36	30,557	5,458	138	5	
6	30	Depreciation	No of Providers/usage	36	36	408,834	1	11,118	6	
7	33	Real Estate Taxes	Patient Days/usage	1,209,117	36	200,354	5,458	784	7	
8	35	Rent-Equipment & Vehicles	Patient Days	1,209,117	36	923,790	5,458	4,170	8	
9	32	Interest	Patient Days/usage	1,209,117	36	1,567,343	5,458	6,693	9	
10	3	Housekeeping	Patient Days	1,209,117	36	421,760	421,760	5,458	1,904	10
11	7	Employee Benefits - Gen'l Services	Patient Days	1,209,117	36	195,292	5,458	882	11	
12	10	Nursing & Medical Record Salaries	Patient Days	1,209,117	36	1,149,694	1,149,694	5,458	5,166	12
13	15	Employee Benefits - Health Care	Patient Days	1,209,117	36	168,303	5,458	760	13	
14	17	Administrative Salary	Patient Days/usage	1,209,117	36	5,264,790	5,264,790	5,458	23,321	14
15	27	Employee Benefits - Admin	Patient Days	1,209,117	36	2,046,057	5,458	9,236	15	
16	19	Professional Fees	Patient Days	1,209,117	36	1,372,458	1,094,350	5,458	20,445	16
17	21	General & Administrative	Patient Days	1,209,117	36	8,525,354	7,617,708	5,458	38,484	17
18	6	Repairs & Maintenance	Patient Days	1,209,117	36	1,379,344	912,301	5,458	8,747	18
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 24,005,407	\$ 16,460,603	\$ 133,435	25	

Facility Name & ID Number

Alden Trails

0042051

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge		X		\$4,317.00	9/1/12	\$ 1,212,967	\$ 1,016,380	12/31/47	2.5000	\$ 25,709	1								
2												2								
3												3								
4	Amort of Fin Fees (GL 7105)		X								1,602	4								
5	Insurance Interest (GL 7035)		X								15	5								
Working Capital																				
6	Related party - AMS		X	Working capital							6,693	6								
7												7								
8												8								
9	TOTAL Facility Related				\$4,317.00		\$ 1,212,967	\$ 1,016,380			\$ 34,019	9								
B. Non-Facility Related*																				
10	Interest Income on R.R.		X								(4)	10								
11	Interest Income (GL 4975)		X									11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(4)	14								
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,016,380			\$ 34,015	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,142 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.	\$	<u>21,661</u>	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.)	\$	<u>19,959</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,702)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>21,329</u>	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.	\$	<u>19,627</u>	7
Real Estate Tax History:	<u>Plus: Related party taxes - See Pg RE_Tax page</u>		8
	<u>Total Real Estate Tax Expense, Sch V, Line 33</u>		784
	\$		<u>20,411</u>

Real Estate Tax Bill for Calendar Year:	2015	<u>19,986</u>	8
	2016	<u>20,280</u>	9
	2017	<u>21,234</u>	10
	2018	<u>21,140</u>	11
	2019	<u>19,959</u>	12

<u>The current year accrual is based on an estimated 3% increase of the prior year tax.</u>			
	13	FROM R. E. TAX STATEMENT FOR 2019	\$
	14	PLUS APPEAL COST FROM LINE 5	\$
	15	LESS REFUND FROM LINE 6	\$
	16	AMOUNT TO USE FOR RATE CALCULATION	\$

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 Trails COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042051

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>784.00</u>
2. <u>02-23-301-016</u>	<u>Nursing Home Facility</u>	\$ <u>19,959.06</u>	\$ <u>19,959.06</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>193,655.06</u></u>	\$ <u><u>20,743.06</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: 6,610 B. General Construction Type: Exterior Brick Veneer 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>38,474</u>	<u>1995</u>	<u>\$ 147,679</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	38,474		\$ 147,679	3

Facility Name & ID Number Alden Trails

0042051

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1997	1997	\$ 934,861	\$ 23,372	40	\$ 23,372	\$	\$ 526,487	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 TV Modules		1999		1,775		5			1,775	9
10	Sprinkler System		1999		1,690		15			1,690	10
11	Replace heads-Irrigation system		1998		1,653		15			1,653	11
12	Carpentry, Ceramic,Quarry, Corain tops		2003		14,274	714	20	714		12,852	12
13	Panels		2003		5,175		5			5,175	13
14	Replaced Floor Tile		2006		2,730		10			2,730	14
15	New Sidewalk Ramp Railing-ABC		2008		3,722	248	15	248		3,317	15
16	Install Automatic Doors-ABC		2008		5,909		10			5,909	16
17	Sealcoat Parking Lot - ABC		2009		4,981		8			4,981	17
18											18
19	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC		2011		11,117	556	20	556		5,421	19
20	Asphalt removal & replacement sealcoating marking restripe-ROSPAV		2011		6,637		8			6,637	20
21	Valve maintenance/install stocked spare head cabinet - USFIRE		2011		2,500		5			2,500	21
22											22
23	ABC - Repair pump/plugged w/ debris, not working		2012		4,819	482	10	482		4,298	23
24	ABC - Replace septic tank pumps		2012		6,829	683	10	683		5,521	24
25											25
26	Sprinkler, Fire Work - ALDBEN		2015		10,015	401	25	401		2,339	26
27	Sprinkler Pipes Replaced - VALFIR		2015		3,262	130	25	130		672	27
28											28
29	Replace Tile in Shower Room - ALDBEN		2017		8,905	228	39	228		855	29
30	Sprinkler, fire, pipes - VALFIR		2017		2,505	501	5	501		1,587	30
31											31
32	Repair Catch Basin - ADVPAV - Parking Lot		2018		6,000	1,200	5	1,200		3,300	32
33	Repair and Repave Catch Basin - ADVPAV - Parking Lot		2018		2,500	500	5	500		1,333	33
34	Repair Dormers - ALDBEN - Roof		2018		2,575	258	10	258		602	34
35	Motor, Washer - EQUINT - Washing Machine		2018		2,654	531	5	531		1,062	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Adj for ABC related party profit	2008	(55)				(55)	37
38	Adj for ABC related party profit	2009	(66)				(66)	38
39	Adj for ABC related party profit	2011	86	6	6		63	39
40	Adj for ABC related party profit	2012	719	62	62		527	40
41	Adj for ABC related party profit	2015	(19)	(2)	(2)		(11)	41
42	Adj for ABC related party profit	2017	(12)	(2)	(2)		(7)	42
43	Adj for ABC related party profit	2018	(8)	(2)	(2)		(5)	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 1,047,733	\$ 29,866		\$ 29,866	\$ 603,142	70

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

Facility Name & ID Number Alden Trails

0042051

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		\$ 1,047,733	\$ 29,866		\$ 29,866	\$	\$ 603,142	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)		\$ 1,194,726	\$ 34,562		\$ 34,562	\$	\$ 698,913	34

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

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 125,152	\$ 9,338	\$ 9,338	\$	various	\$ 58,319	71
72	Current Year Purchases	20,334	516	516		various	516	72
73	Fully Depreciated Assets	253,992	1,291	1,291		various	253,992	73
74								74
75	TOTALS	\$ 399,478	\$ 11,145	\$ 11,145	\$		\$ 312,827	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	2001 - Bus Midwest Transit	2001	\$ 16,646	\$	\$	\$		\$ 16,646	76
77	related party-AMS	various	1998-2004	3,802				3	3,802	77
78	Transport	Bus	2000&2003	6,558					6,558	78
79										79
80	TOTALS			\$ 27,006	\$	\$	\$		\$ 27,006	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 1,768,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,707	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,707	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)	\$ 1,038,746	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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 12/02/1996

Ending 11/30/2036

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

Fiscal Year Ending Annual Rent

12. 12/31/21 \$ Varies

13. 12/31/22 \$ Varies

14. 12/31/23 \$ 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: \$ 1,710 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>Related Party - Pg 6A</u>	<u>Various</u>	\$ <u>161.67</u>	\$ <u>1,940</u>	17
18					18
19	<u>Auto Lease GL 6890</u>		<u>0.00</u>	<u>0</u>	19
20					20
21	TOTAL		\$ <u>161.67</u>	\$ <u>1,940</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)	\$			

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See PG16A	# of prescripts				2,793		2,793	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					6,295		6,295	13
14	TOTAL			\$		\$	\$ 9,088		\$ 9,088	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		
2.	ST	39-3	To Col 5		
3.					
4.	PT	39-3	To Col 5		
5.					
6.					
7.					
8.	Pharmacy Supplies per GL			2,730.00	
	Manual Input from Related Party- Forum Drugs & Vaccinations			63.00	From Page 6C. Ln 39, Col 8 Drug Items
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	2,793.00	
10.					
11.					
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00	
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00	
	Total Exceptional Care (Line 12, Col 8)			0.00	
13.	Other: Transport. Specialist (6001-100-019)		See Pg 16A		
13.	Col 5: Manual Input: Related Party - CPT		To Col 5		From Page 6D, Col 8 (Except DD homes)
	Other			13,697.00	
	Manual Input: Related Party - Prism			(7,426.00)	From Page 6B/Ln 39 items, Col 8
	Manual Input: Related Party FECII - I.V.				From Page 6C/Ln 39 items for IV, Col 8
	Manual Input: Related Party FECII - Wound Care-Products Only			(10.00)	From Page 6C/Ln 39 items for Wound Care Products, Col 8
	Oxygen, from reclass worksheet (Pg 4A)			34.00	
13.	Col 6: Supplies Total		To Col 6	6,295.00	
13.	Total Line 13, Column 8			6,295.00	
14.	Total			9,088.00	

Facility Name & ID Number Alden Trails

0042051

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	\$	\$ 4,157	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250))	148,862	148,862	3
4	Supply Inventory (priced at)	46,010	46,010	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,693	6
7	Other Prepaid Expenses	9,512	9,512	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 204,384	\$ 214,234	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,679	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	55,562	102,248	15
16	Equipment, at Historical Cost	122,616	378,099	16
17	Accumulated Depreciation (book methods)	(142,126)	(896,130)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		16,294	21
22	Other Long-Term Assets (spe Refinancing		23,767	22
23	Other(specify): Due From Affiliates	1,450,880	1,485,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,486,932	\$ 2,192,611	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,691,316	\$ 2,406,845	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 197,353	\$ 198,753	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,416	6,416	28
29	Short-Term Notes Payable		26,700	29
30	Accrued Salaries Payable	80,626	80,626	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,207	26,207	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,574	32
33	Accrued Interest Payable		2,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accr Exp/Ins., Due to IDPA, Sales Tax, M	774,895	774,895	36
37	Due to Affiliates - Current	55,112	55,112	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,140,609	\$ 1,191,400	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		989,680	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	Deferred FICA	17,797	17,797	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,797	\$ 1,007,477	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,158,406	\$ 2,198,877	46
47	TOTAL EQUITY(page 18, line 24)	\$ 532,910	\$ 207,968	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,691,316	\$ 2,406,845	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 617,600	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded	74,564	3
4	after prior year report submitted and allocated costs.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 692,164	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(159,254)	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)	\$ (159,254)	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)	\$ 532,910	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	\$ 1,413,353	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,413,353	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Pg 19A	327,544	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 327,544	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,740,897	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	239,673	31
32	Health Care	739,576	32
33	General Administration	391,837	33
B. Capital Expense			
34	Ownership	106,929	34
C. Ancillary Expense			
35	Special Cost Centers	343,485	35
36	Provider Participation Fee	78,651	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,900,151	40
41	Income before Income Taxes (line 30 minus line 40)**	(159,254)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (159,254)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,413,353	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Hospice		47
48	Other-(specify) Insur,Vets,Charity/Sales Allows		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,413,353	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 Trails# 0042051

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
GL 461500-100-000 Day Training Income	\$ 327,058
GL 498500-100-000 Gain on Sale of Assets	\$ 486

Line 28 Total: 327,544

Facility Name & ID Number Alden Trails

0042051

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
2	Assistant Director of Nursing				2
3	Registered Nurses	2,279	111,276	46.56	3
4	Licensed Practical Nurses	2,459	72,940	26.98	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	512	11,858	22.80	9
10	Activity Assistants	514	9,047	17.40	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	3,590	80,380	18.38	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,418	26,831	17.21	18
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	518	21,048	40.48	22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	298	5,801	17.90	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	21,377	434,064	18.22	30
31	Medical Records				31
32	Other Health Care Behavioral Special	345	11,401	32.86	32
33	Other(specify) Facility Manager	1,024	30,948	29.76	33
34	TOTAL (lines 1 - 33)	34,334	\$ 815,594 *	\$ 21.39	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	\$ 4,910	1-3	35
36	Medical Director	3,600	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant		10-3	38
39	Pharmacist Consultant	384	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	180	11-3	44
45	Social Service Consultant	1,120	11-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,194		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		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		
Jennifer Kristy Moran	Executive Director	0	\$ 0	Workers' Compensation Insurance	\$ 22,098	IDPH License Fee	\$		
allocated cost		0		Unemployment Compensation Insurance	2,176	Advertising: Employee Recruitment	92		
		0		FICA Taxes	53,927	Health Care Worker Background Check	0		
		0		Employee Health Insurance	70,913	(Indicate # of checks performed)			
		0		Employee Meals	8,789	Patient Background Checks	9 90		
		0		Illinois Municipal Retirement Fund (IMRF)*		Surety Bonds	200		
		0		Insurance (Dental, Life, Vision)	408	Corporate Annual Fee	77		
				Employee Relations	951	Broadcast Radio	102		
				Miscellaneous Payroll	281	Center for Developmental Disabilities/Collabo	1,253		
				Drug/Covid Testing	1,476	Related party-AMS	138		
				Vaccination	202	Less: Public Relations Expense	()		
				401K Match	769	Non-allowable advertising	()		
				Related Party - Forum	(202)	Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 161,788	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,952		
(List each licensed administrator separately.)									
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		
							Related party-AMS	116	
							Seminar Expense		
							Wisconsin Health Care Association Fall Conf	135	
							Ill. Assoc. of Rehab Facilities Virtual Annual	81	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 332	
(Attach a copy of any management service agreement)									
C. Professional Services				* Attach copy of IMRF notifications			**See instructions.		
Vendor/Payee	Type		Amount						
Alden Management Services	consulting fee		\$ 76,334						
Mid-Cap	Legal Fees		74						
AMS Legal Fees	Legal Fees		25,200						
MPRO Administration Org.	Professional Fees		619						
Mid-Cap	Accounting Fees		484						
Baker Tilly	Accounting Fees		3,641						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 106,352						
(For legal fee disclosure, see page 39 of instructions)									

Alden Trails PG 21A
 Legal Fee Support
 2020

Legal Fees Reported on Pg 21, Section C: \$ 25,274.00

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

Non-allowable legal fees, if any, deducted on (25,200.00)
 - AMS Allocated Legal Fees: GL 680600-100-003
 + Add Back voided invoice of prior year, if any
 Allowable Legal Fees \$ 74.00

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
Mid-Cap	6/20,7/20,10/20	74.00
TOTAL ALLOWABLE LEGAL FEES		<u>74.00</u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		<u>-</u>

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Amount</u>
AMS Allocated Legal Fees	1/1/20- 12/31/20	25,200.00

TOTAL Allocated Legal Fees 25,200.00

Total Legal Cost 25,274.00

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Hab:Yes;RN/LPN:No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. The Center for Developmental Disabilities - \$1253
- (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. \$ 9,668 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. _____
- (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. \$ 78,651
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. \$ 8,789 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: _____
- (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.