

		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.

I. IDPH License ID Number: 0054650 Facility Name: AVONDALE ESTATES OF ELGIN Address: 1754 1760 CAPITAL ST ELGIN 60124 County: KANE Telephone Number: 847-531-6004 Fax #: 847-531-6006 HFS ID Number: Date of Initial License for Current Owners: 8/1/17 Type of Ownership: VOLUNTARY, NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual X Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: KATHLEEN MCNAMARA Telephone Number: (847) 675-3585 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) EREZ BAVER (Title) MEMBER (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) Paid Preparer (Print Name and Title) KATHLEEN MCNAMARA VICE-PRESIDENT (Firm Name & Address) KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714 (Telephone) (847) 675-3585 Fax #: (847) 675-3585 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number AVONDALE ESTATES OF ELGIN

0054650 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>802</u>	<u>16,797</u>	<u>17,599</u>	8
9	SNF/PED					9
10	ICF	<u>1,065</u>			<u>1,065</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,065</u>	<u>802</u>	<u>16,797</u>	<u>18,664</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.50%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 08/01/17

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/17 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 120 and days of care provided 16,797

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **AVONDALE ESTATES OF ELGIN** # **0054650** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	281,899	19,874	21,272	323,045		323,045		323,045			1
2	Food Purchase		173,332		173,332		173,332		173,332			2
3	Housekeeping	179,808	58,058		237,866		237,866		237,866			3
4	Laundry	10,406	6,889	310	17,605		17,605		17,605			4
5	Heat and Other Utilities			102,104	102,104		102,104		102,104			5
6	Maintenance	81,763	83,892	67,687	233,342		233,342		233,342			6
7	Other (specify):*			16,010	16,010		16,010		16,010			7
8	TOTAL General Services	553,876	342,045	207,383	1,103,304		1,103,304		1,103,304			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,906,421	433,826	61,083	3,401,330		3,401,330		3,401,330			10
10a	Therapy		2,067	48,830	50,897		50,897		50,897			10a
11	Activities	80,689	10,048	19,649	110,386		110,386		110,386			11
12	Social Services	93,066			93,066		93,066		93,066			12
13	CNA Training											13
14	Program Transportation			28,491	28,491		28,491		28,491			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,080,176	445,941	182,053	3,708,170		3,708,170		3,708,170			16
	C. General Administration											
17	Administrative	149,102		617,429	766,531		766,531	(617,429)	149,102			17
18	Directors Fees											18
19	Professional Services			105,461	105,461		105,461	1,000	106,461			19
20	Dues, Fees, Subscriptions & Promotions			96,184	96,184		96,184	(66,888)	29,296			20
21	Clerical & General Office Expenses	243,736	53,049	208,783	505,568		505,568	(137,049)	368,519			21
22	Employee Benefits & Payroll Taxes			615,394	615,394		615,394		615,394			22
23	Inservice Training & Education			240	240		240		240			23
24	Travel and Seminar			18,134	18,134		18,134	(18,134)				24
25	Other Admin. Staff Transportation			2,299	2,299		2,299		2,299			25
26	Insurance-Prop.Liab.Malpractice			163,791	163,791		163,791		163,791			26
27	Other (specify):* HR COORD/MARKETING			464,239	464,239		464,239	(464,239)				27
28	TOTAL General Administration	392,838	53,049	2,291,954	2,737,841		2,737,841	(1,302,739)	1,435,102			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,026,890	841,035	2,681,390	7,549,315		7,549,315	(1,302,739)	6,246,576			29

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

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

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	20,237		CONTRACT NURSING	XVIII C 53-2	
	REPAIRS & MAINTENANCE		1,035		LABORATORY & XRAY EXPENSE		0
	CONTRACTED DIETARY SERVICES		0		PURCHASED SERVICES		0
			21,272		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
3	HOUSEKEEPING				RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	54,752
	CONTRACTED HOUSEKEEPING SERVICES		0		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
			0		PHARMACY CONSULTANT	XVIII B 39-2	6,331
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	0
	EQUIPMENT REPAIRS & MAINTENANCE		310		PHYSICIANS	XVIII B __-2	0
	CONTRACTED LAUNDRY SERVICES		0		PSYCHIATRIC	XVIII B __-2	0
			310		RN CONSULTANT	XVIII B 38-2	0
5	HEAT & OTHER UTILITIES						
	GAS HEAT		13,376				
	ELECTRICITY		58,612				
	WATER		30,116				61,083
	CABLE TV - LOBBY		0	10a	THERAPY		
			102,104		PHYSICAL THERAPY SERVICES		0
6	MAINTENANCE				SPEECH THERAPY SERVICES		0
	GROUNDS MAINTENANCE		13,976		OCCUPATIONAL THERAPY SERVICES		0
	PAINTING & DECORATING		6,655		REHABILITATION CONSULTANT	XVIII B __-2	0
	BUILDING REPAIRS		0		PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	MAINTENANCE TRAVEL		0		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	EQUIPMENT MAINTENANCE & REPAIR		2,761		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	48,830
	ELEVATOR MAINTENANCE & REPAIR		23,105		SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	OUTSIDE LABOR		8,968				
	EXTERMINATING SERVICE		4,005				48,830
	FIRE SERVICE		8,217	11	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		18,865
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	784
			67,687				19,649
7	OTHER			12	SOCIAL SERVICES		
	SCAVENGER		16,010		SOCIAL REHABILITATION SERVICES		0
	SECURITY SERVICE		0		SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
					SOCIAL WORKER	XVIII B 45-2	0
			16,010				0
9	MEDICAL DIRECTOR			13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		24,000		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	PATIENT TRANSPORTATION		28,491		FICA TAXES	XIX D	303,656
			28,491		UNEMPLOYMENT COMPENSATION	XIX D	50,883
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANCE	XIX D	117,314
	MANAGEMENT FEES	XIX B	617,429		HOSPITALIZATION INSURANCE	XIX D	78,893
	DIRECTORS FEES				EMPLOYEE BENEFITS - OTHER	XIX D	64,648
18	DIRECTORS FEES		0		EMPLOYEE PHYSICAL EXAMS	XIX D	0
19	PROFESSIONAL SERVICES				INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	DATA PROCESSING	XIX C	83,459		PENSION/PROFIT SHARING PLANS	XIX D	0
	ADMINISTRATIVE CONSULTANTS	XIX C	0				
	PROFESSIONAL FEES	XIX C	22,002				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0				615,394
			105,461	23	INSERVICE TRAINING & EDUCATION		
20	FEES,SUBSCRIPTIONS,PROMOTIONS				EDUCATION & SEMINARS		240
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0				240
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	61,888	24	TRAVEL & SEMINARS		
	EMPLOYEE WANT ADS	XIX F	1,731		EDUCATION & SEMINARS	XIX G	0
	CONTRIBUTIONS	VI 20 XIX F	5,000		TRAVEL	XIX G	18,134
	DUES & SUBSCRIPTIONS	XIX F	19,534				
	LICENSES & PERMITS	XIX F	770				18,134
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	25	ADMIN. STAFF TRANSPORTATION		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0		TRANSPORTATION - STAFF		2,299
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0				2,299
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	26	INSURANCE - PROP. LIAB & MALPRACTICE		
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	318		GENERAL INSURANCE		163,791
	PATIENT BACKGROUND CHECKS	XIX F	6,943				
			96,184				163,791
21	CLERICAL & GENERAL OFFICE EXPENSES			27	OTHER		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,122		BAD DEBTS	VI 24	464,239
	EQUIPMENT REPAIR & MAINTENANCE		20,235				464,239
	OUTSIDE CLERICAL SERVICES		150,000				
	PENALTIES / OVERDRAFT CHARGES	VI 18	0				
	HOME OFFICE EXPENSE		0				
	THEFT & DAMAGE LOSS		0				
	TELEPHONE		32,426				
	MESSENGER SERVICE		0				
			208,783				

GRAND TOTAL COLUMN 3 OTHER

2,681,390

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			66,419	66,419		66,419	(54,572)	11,847			30
31	Amortization of Pre-Op. & Org.			976	976		976		976			31
32	Interest			35,080	35,080		35,080	(625)	34,455			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,748,264	1,748,264		1,748,264		1,748,264			34
35	Rent-Equipment & Vehicles			71,822	71,822		71,822		71,822			35
36	Other (specify):*											36
37	TOTAL Ownership			1,922,561	1,922,561		1,922,561	(55,197)	1,867,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		950,206	1,501,238	2,451,444		2,451,444		2,451,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,212	99,212		99,212		99,212			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		950,206	1,600,450	2,550,656		2,550,656		2,550,656			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,026,890	1,791,241	6,204,401	12,022,532		12,022,532	(1,357,936)	10,664,596			45

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

VI. ADJUSTMENT DETAIL

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

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(54,572)	30		9
10	Interest and Other Investment Income	(625)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(5,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(464,239)	27		24
25	Fund Raising, Advertising and Promotional	(61,888)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(156,057)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (742,381)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(615,555)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (615,555)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,357,936)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (137,923)	21	1
2	NON ALLOWABLE TRAVEL	(18,134)	24	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(156,057)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVONDALE ESTATES OF ELGIN# 0054650

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(617,429)	0	0	0	0	0	0	0	0	0	(617,429)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,000	0	0	0	0	0	0	0	0	0	1,000	19
20	Fees, Subscriptions & Promotions	(66,888)	0	0	0	0	0	0	0	0	0	0	(66,888)	20
21	Clerical & General Office Expenses	(137,923)	874	0	0	0	0	0	0	0	0	0	(137,049)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(18,134)	0	0	0	0	0	0	0	0	0	0	(18,134)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(464,239)	0	0	0	0	0	0	0	0	0	0	(464,239)	27
28	TOTAL General Administration	(687,184)	(615,555)	0	0	0	0	0	0	0	0	0	(1,302,739)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(687,184)	(615,555)	0	0	0	0	0	0	0	0	0	(1,302,739)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVONDALE ESTATES OF ELGIN # 0054650 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(54,572)	0	0	0	0	0	0	0	0	0	0	(54,572)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(625)	0	0	0	0	0	0	0	0	0	0	(625)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(55,197)	0	0	0	0	0	0	0	0	0	0	(55,197)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(742,381)	(615,555)	0	0	0	0	0	0	0	0	0	(1,357,936)	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
SEE PG6-SUPP						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 617,429	AVONDALE CONSULTING GROUP, LLC	100.00%	\$	\$ (617,429)	1
2	V								2
3	V	19	PROFESSIONAL FEES				1,000	1,000	3
4	V	21	OFFICE EXPENSE				874	874	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 617,429			\$ 1,874	\$ * (615,555)	14

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

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								1
2	EREZ BAVER	99.00			AVONDALE	SKOKIE	CONSULTING	2
3					GONSULTING			3
4	RIVKAH BAVER	1.00			GROUP			4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number AVONDALE ESTATES OF ELGIN # 0054650 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 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	EREZ BAVER	MEMBER	ADMINISTRATIV	99.00		60	91.67	consult fee	\$ 200,000	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 200,000		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 AVONDALE ESTATES OF ELGIN # 0054650 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9					N/A					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	TOTALS					\$	\$		\$	25

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							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	BUSEY BANK		X	WORKING CAPITAL	INT ONLY	11/20/18		700,000	REVOLV		35,080	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	700,000				\$ 35,080	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$					\$	14						
15	TOTALS (line 9+line14)						\$	700,000				\$ 35,080	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
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.)			\$ 298,987	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 298,987	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$ 298,987	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	8		
	2016	9		
	2017	10		
	2018	307,136		
	2019	298,987		
			FOR BHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVONDALE ESTATES OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0054650

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 03-31-226-003	NURSING HOME	\$ 298,986.70	\$ 298,986.70
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 298,986.70	\$ 298,986.70

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.

A. Square Feet: 52,090

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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).

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:

14,643

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

976

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	ANNUNCIATOR PANEL ON SECOND FLOOR GENERATOR			2017	2,639	68	39	68		207
10	NEW WINDOW			2017	1,150	29	39	29		88
11	SIGNS			2018	14,471	965	15	965		2,171
12										12
13	PER AUDIT				(1,150)					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

*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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 17,110	\$ 1,062		\$ 1,062	\$	\$ 2,466	70

**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	\$ 75,641	\$ 6,185	\$ 7,564	\$ 1,379		\$ 17,195	71
72	Current Year Purchases	64,422	59,172	3,221	(55,951)		3,221	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 140,063	\$ 65,357	\$ 10,785	\$ (54,572)		\$ 20,416	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	157,173
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	66,419
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	11,847
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(54,572)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	22,882

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: ELGIN-J-DEK LP
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:		120	8/1/17	\$ 1,748,264	7	10	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,748,264			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☒ NO Terms: *

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: \$ 71,822 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			N/A		19
20					20
21	TOTAL		\$	\$	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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	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	\$		\$ 637,855	\$		\$ 637,855	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			138,111			138,111	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			725,272			725,272	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				751,466		751,466	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					198,740		0 198,740	13
14	TOTAL			\$		\$ 1,501,238	\$ 950,206		\$ 2,451,444	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,123,105	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 156,000)	1,695,135		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,485		6
7	Other Prepaid Expenses	31,061		7
8	Accounts Receivable (owners or related parties)	8,600		8
9	Other(specify): DUE FROM OTHERS	59,335		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,049,721	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	18,259		15
16	Equipment, at Historical Cost	168,812		16
17	Accumulated Depreciation (book methods)	(165,706)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	14,643		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,416)		20
21	Restricted Funds	147,000		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 179,592	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,229,313	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,788,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	700,000		29
30	Accrued Salaries Payable	205,976		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,419		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SBA PPP LOAN	595,700		36
37	DUE TO PRIOR OWNER	38,320		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,351,726	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,351,726	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,122,413)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,229,313	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (597,296)	1
2	Restatements (describe):		2
3	PRIOR	27,499	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (569,797)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	256,288	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	(808,904)	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)	\$ (552,616)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,122,413)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number AVONDALE ESTATES OF ELGIN

0054650

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,156,611	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,156,611	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***	625	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 625	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	1,121,584	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,121,584	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,278,820	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,103,304	31
32	Health Care	3,708,170	32
33	General Administration	2,737,841	33
	B. Capital Expense		
34	Ownership	1,922,561	34
	C. Ancillary Expense		
35	Special Cost Centers	2,451,444	35
36	Provider Participation Fee	99,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,022,532	40
41	Income before Income Taxes (line 30 minus line 40)**	256,288	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 256,288	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 235,917	44
45	Private Pay - Net Inpatient Revenue	296,630	45
46	Medicare - Net Inpatient Revenue	8,124,955	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	2,499,109	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,156,611	49

**TAX RETURN PRE

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

PARED ON CASH
BASIS** Does this agree with taxable income (loss) per Federal Income
Tax Return? NO** If not, please attach a reconciliation.*** See the instructions. If this total amount has not been offset against interest
expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,808	2,048	\$ 123,541	\$ 60.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,595	34,977	1,283,513	36.70	3
4	Licensed Practical Nurses	13,881	14,445	521,026	36.07	4
5	CNAs & Orderlies	42,255	43,774	767,274	17.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,996	2,068	55,176	26.68	9
10	Activity Assistants	2,612	2,670	25,513	9.56	10
11	Social Service Workers	3,365	3,517	93,066	26.46	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,072	51,420	24.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,999	17,602	230,479	13.09	15
16	Dishwashers					16
17	Maintenance Workers	2,791	2,869	81,763	28.50	17
18	Housekeepers	10,985	11,351	179,808	15.84	18
19	Laundry	1,249	1,305	10,406	7.97	19
20	Administrator	4,064	4,104	149,102	36.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,287	9,665	243,736	25.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,027	2,075	41,419	19.96	31
32	Other Health C: Care Plan Coordin	4,153	4,306	169,648	39.40	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,059	158,848	\$ 4,026,890 *	\$ 25.35	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	M	\$ 20,237	1-3	35
36	Medical Director	O	24,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	54,752	10-3	38
39	Pharmacist Consultant	H	6,331	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		48,830	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	784	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 154,934		49

C. CONTRACT NURSES

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

Facility Name & ID Number		AVONDALE ESTATES OF ELGIN		STATE OF ILLINOIS		# 0054650		Report Period Beginning:		1/1/2020		Page 21		Ending: 12/31/2020	
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	
ALLISON BERTACCHI		ADMINISTRATOR		0		\$ 149,102		Workers' Compensation Insurance		\$ 117,314		IDPH License Fee		\$	
								Unemployment Compensation Insurance		50,883		Advertising: Employee Recruitment		1,731	
								FICA Taxes		303,656		Health Care Worker Background Check		318	
								Employee Health Insurance		78,893		(Indicate # of checks performed 29)			
								Employee Meals		0		Patient Background Checks		597	
								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		5,000	
								EMPLOYEE BENEFITS - OTHER		64,648		MARKETING/ADV/PROMO		61,888	
								EMPLOYEE PHYSICAL EXAMS		0		LICENSES/DUES/SUBSCRIPTIONS		20,304	
								PENSION/PROFIT SHARING PLANS		0		MGMT CO ALLOC			
								INSURANCE - EXECUTIVE LIFE		0		TRUST/FRANCHISE/CONTRIB/ETC		(5,000)	
												Less: Public Relations Expense		(0)	
												Non-allowable advertising		(61,888)	
								INSURANCE - EXECUTIVE LIFE VI 21		0		Yellow page advertising		(0)	
TOTAL (agree to Schedule V, line 17, col. 1)						\$ 149,102		TOTAL (agree to Schedule V, line 22, col.8)		\$ 615,394		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,296	
(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			
AVONDALE CONSULTING MANAGEMENT FEES		\$ 617,429						\$		Out-of-State Travel		\$			
										In-State Travel					
										NON ALLOW		18,134			
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 617,429								Seminar Expense					
(Attach a copy of any management service agreement)												0			
C. Professional Services															
Vendor/Payee		Type		Amount											
MATRIXCARE		DATA PROCESSING		\$ 37,064											
PATIENT PING, INC.		DATA PROCESSING		10,800											
PROPAY HR		DATA PROCESSING		26,929											
ALLSCRIPTS		DATA PROCESSING		3,600											
NORTON		DATA PROCESSING		106											
BILL.COM		DATA PROCESSING		4,960											
STUTI O'BRYAN		MDS CONSULTING		3,900											
KBKB LTD		ACCOUNTING FEES		8,500											
AMSTADTER ARCHITECT		ARCHITECT CONSULTING		1,538											
SEE LEGAL SCHEDULE ATTACHED				8,064											
TOTAL (agree to Schedule V, line 19, column 3)				\$ 105,461				\$				Entertainment Expense (agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)												TOTAL		\$ 18,134	
				* Attach copy of IMRF notifications								**See instructions.			

AVONDALE ESTATES OF ELGIN**SCHEDULE - LEGAL****12/31/2020****INVOICE FIRM****DATE NAME****DESCRIPTION****AMOUNT**

2/1/2020 DICKLER, KAHN, SLOWIKOWSKI & ZAVELL, LTD RESIDE ADMISSIONS CT (REG) 414.15

3/1/2020 DICKLER, KAHN, SLOWIKOWSKI & ZAVELL, LTD RESIDE ADMISSIONS CT (REG) 192.50

3/12/2020 JOHNSON & BELL LTD. COURT CASE 517.25

4/7/2020 JOHNSON & BELL LTD. COURT CASE 817.00

5/12/2020 JOHNSON & BELL LTD. COURT CASE 120.00

6/10/2020 JOHNSON & BELL LTD. COURT CASE 382.00

8/28/2020 JOHNSON & BELL LTD. COURT CASE 129.00

8/31/2020 JOHNSON & BELL LTD. COURT CASE 1,159.00

11/12/2020 JOHNSON & BELL LTD. COURT CASE 1,155.00

12/9/2020 JOHNSON & BELL LTD. COURT CASE 192.00

7/17/2020 NEAL, GERBER & EISENBERG LLP EMPLOYMENT PRACTICES 219.60

6/30/2020 O-KEEFE LYONS & HYNES LLC TAX APPEAL 2,766.96

TOTAL**8,064.46**

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>10 YR</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>6,952</u> Line <u>10-2</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>99,212</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>YES</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>NO</u>
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? <u>5%</u>
 d. Have vehicle usage logs been maintained? <u>NO</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>NO</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>YES</u>
 g. Does the facility transport residents to and from day training? <u>NO</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> </p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(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. <u>YES</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|