

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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

NumberCityZip Code

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	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:

Name: Larry Templin Telephone Number: (630) 361-2868

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 1/1/2025 to 12/31/2025 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) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Avondale Estates of Elgin # 0054650 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						12,916	7,308	20,224	8
9	SNF/PED									9
10	ICF	944	523	429		2,394			4,290	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	944	523	429		2,394	12,916	7,308	24,514	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 55.97%

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 ☒ Non-allowable costs have been eliminated in Schedule V, Column _____

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 8/1/17

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 8/1/17 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of certified beds 120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	386,001	31,508	32,940	450,449		450,449		450,449			1
2	Food Purchase		236,985		236,985		236,985	(1,077)	235,908			2
3	Housekeeping	181,829	72,260		254,089		254,089		254,089			3
4	Laundry	32,458	7,230		39,688		39,688		39,688			4
5	Heat and Other Utilities			190,149	190,149		190,149	1,761	191,910			5
6	Maintenance	111,455	3,725	86,049	201,229		201,229	5,413	206,642			6
7	Other (specify):* Waste Disposal			21,267	21,267		21,267		21,267			7
8	TOTAL General Services	711,743	351,708	330,405	1,393,856		1,393,856	6,097	1,399,953			8
	B. Health Care and Programs											
9	Medical Director			26,000	26,000		26,000		26,000			9
10	Nursing and Medical Records	4,429,144	233,355	5,350	4,667,849		4,667,849	93,135	4,760,984			10
10a	Therapy			40,661	40,661		40,661	(40,661)				10a
11	Activities	119,964	9,260		129,224		129,224		129,224			11
12	Social Services	149,747			149,747		149,747		149,747			12
13	CNA Training											13
14	Program Transportation	41,230		10,087	51,317		51,317		51,317			14
15	Other (specify):* Mgmt Co Benefits Alloc							24,455	24,455			15
16	TOTAL Health Care and Programs	4,740,085	242,615	82,098	5,064,798		5,064,798	76,929	5,141,727			16
	C. General Administration											
17	Administrative	159,957		734,111	894,068		894,068	(602,569)	291,499			17
18	Directors Fees											18
19	Professional Services			305,473	305,473		305,473	18,352	323,825			19
20	Dues, Fees, Subscriptions & Promotions			56,099	56,099		56,099	13,260	69,359			20
21	Clerical & General Office Expenses	283,149	14,330	307,303	604,782		604,782	201,501	806,283			21
22	Employee Benefits & Payroll Taxes			762,900	762,900		762,900		762,900			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,612	1,612		1,612	7,029	8,641			24
25	Other Admin. Staff Transportation			13,564	13,564		13,564	(2,443)	11,121			25
26	Insurance-Prop.Liab.Malpractice			324,921	324,921		324,921	8,936	333,857			26
27	Other (specify):* Mgmt Co Benefits Alloc							101,284	101,284			27
28	TOTAL General Administration	443,106	14,330	2,505,983	2,963,419		2,963,419	(254,650)	2,708,769			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,894,934	608,653	2,918,486	9,422,073		9,422,073	(171,624)	9,250,449			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			41,304	41,304		41,304	(14,172)	27,132			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,814	137,814		137,814	85,728	223,542			32
33	Real Estate Taxes			195,742	195,742		195,742	17,088	212,830			33
34	Rent-Facility & Grounds			1,556,857	1,556,857		1,556,857	18,885	1,575,742			34
35	Rent-Equipment & Vehicles			115,537	115,537		115,537	7,088	122,625			35
36	Other (specify):* Loan Costs/Amort			44,852	44,852		44,852		44,852			36
37	TOTAL Ownership			2,092,106	2,092,106		2,092,106	114,617	2,206,723			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		694,246	2,170,453	2,864,699		2,864,699	(409,353)	2,455,346			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,643	101,643		101,643		101,643			42
43	Other (specify):* Disallowed Costs	85,466	19,007	277,167	381,640		381,640	(381,640)				43
44	TOTAL Special Cost Centers	85,466	713,253	2,549,263	3,347,982		3,347,982	(790,993)	2,556,989			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,980,400	1,321,906	7,559,855	14,862,161		14,862,161	(848,000)	14,014,161			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(14,055)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,131)	30		9
10	Interest and Other Investment Income	(823)	32		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	(3,370)	17		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,260)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(40,915)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,232)	43		24
25	Fund Raising, Advertising and Promotional	(9,067)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,952)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(832,516)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,154,321)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	306,321		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 306,321		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (848,000)		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.		X	\$		38
39						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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Miscellaneous Income offset	(1,077)	2	3
4	Miscellaneous Income offset	(709)	21	4
5	Marketing Salary	(85,466)	43	5
6	Disallow Marketing Consultants	(14,400)	43	6
7	Disallow Marketing Supplies	(19,007)	43	7
8	Disallow Late Fees	(5,201)	43	8
9	Disallow Mgmt Fees from Avondale Consulting Group	(734,111)	17	9
10	Adjust Real Estate Taxes to Actual	17,088	33	10
11	Disallow Marketing Travel Exp	(2,530)	25	11
12	Expense Repairs/Equipment under \$2,500	4,942	6	12
13	Expense Repairs/Equipment under \$2,500	3,233	21	13
14	Capitalize Leasehold Improvements over \$2500	(3,438)	6	14
15	Accrue 2025 Legal Invoices	8,160	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(832,516)		49

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 Page 6 Supplemental		See Page 6 Supplemental		

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	5	Utilities	\$	Premier Healthcare Management, LLC	0.00%	\$ 1,761	\$ 1,761	1
2	V	6	Maintenance		Premier Healthcare Management, LLC	0.00%	3,909	3,909	2
3	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	0.00%	93,135	93,135	3
4	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	0.00%	24,455	24,455	4
5	V	17	Administrative		Premier Healthcare Management, LLC	0.00%	134,912	134,912	5
6	V	19	Professional Services		Premier Healthcare Management, LLC	0.00%	10,266	10,266	6
7	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	0.00%	1,635	1,635	7
8	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	0.00%	230,248	230,248	8
9	V	24	Travel and Seminar		Premier Healthcare Management, LLC	0.00%	322	322	9
10	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	0.00%	1,880	1,880	10
11	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	0.00%	92,370	92,370	11
12	V	30	Depreciation		Premier Healthcare Management, LLC	0.00%	4,039	4,039	12
13	V								13
14	Total			\$			\$ 598,932	\$ * 598,932	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	34	Rent-Facility & Grounds	\$	Premier Healthcare Management, LLC	0.00%	\$ 16,972	\$ 16,972	15
16	V	35	Equipment Rental		Premier Healthcare Management, LLC	0.00%	7,088	7,088	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			\$			\$ 24,060	\$ * 24,060	39

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	\$40,661	REX Therapeutics	0.00%	\$	\$(40,661)	15
16	V	19	Professional Services		REX Therapeutics	0.00%	40,841	40,841	16
17	V	20	Fees and Subscriptions		REX Therapeutics	0.00%	11,625	11,625	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	0.00%	36,105	36,105	18
19	V	24	Travel and Seminar		REX Therapeutics	0.00%	6,707	6,707	19
20	V	25	Other Admin Staff Transp		REX Therapeutics	0.00%	87	87	20
21	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	0.00%	7,056	7,056	21
22	V	30	Depreciation		REX Therapeutics	0.00%	920	920	22
23	V	32	Interest Expense		REX Therapeutics	0.00%	86,551	86,551	23
24	V	34	Rent-Facility & Grounds		REX Therapeutics	0.00%	1,913	1,913	24
25	V	39	Therapy Management Wages		REX Therapeutics	0.00%	107,397	107,397	25
26	V	39	Therapy Consultant	1,879,889	REX Therapeutics	0.00%	184	(1,879,705)	26
27	V								27
28	V	39	Therapy Wages		REX Therapeutics	0.00%	1,195,306	1,195,306	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	0.00%	167,649	167,649	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$1,920,550			\$1,662,341	\$*(258,209)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	21	Clerical & General Office Exp	\$ 180,000	Healthcare Solutions Group	50.00%	\$ 112,624	\$ (67,376)	15
16	V	27	Emp Benefit Alloc-Gen Admin		Healthcare Solutions Group	50.00%	8,914	8,914	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			\$ 180,000			\$ 121,538	\$ * (58,462)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ownership Listing-1

ID# 0054650

1/1/2025

12/31/2025

Management

Operator/Licensee

Ownership

1	2
3	4
5	6
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75	

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			AHVA Care of Winfield	Winfield, IL	Premier Healthcare	Skokie, IL	Management Co.	
2			AHVA Care of Stickney	Stickney, IL	Management, LLC			
3			Gilman Healthcare Center	Gilman, IL	Premier Healthcare	Skokie, IL	Medical Supply	
4			Premier Healthcare of New Harmony, LLC	New Harmony, IN	Supplies, LLC			
5			Norridge Gardens	Norridge, IL	REX Therapeutics	Skokie	Therapy	
6					Healthcare Solutions			
7					Group	Skokie	Billing Services	
8					Staffing Solutions			
9					Partners	Skokie	Staffing Services	
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								

SEE ACCOUNTANTS' PREPARATION REPORT

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	David Levi	Owner	Clerical	50.00	See Att Sch 7A	7.49	18.73	Alloc Salary	\$ 20,953	21-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 20,953		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: 1/1/2025 Ending: 2/31/2025

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 Premier Healthcare Management, LLC
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	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	Weighted Operating Rev	78,891,476	8	\$ 9,406	\$	14,769,914	\$ 1,761	1
2	6	Maintenance	Weighted Operating Rev	78,891,476	8	20,881		14,769,914	3,909	2
3	10	Nursing and Medical Records	Weighted Operating Rev	78,891,476	8	497,470	497,470	14,769,914	93,135	3
4	15	Emp Benefit Alloc-Healthcare	Weighted Operating Rev	78,891,476	8	130,621		14,769,914	24,455	4
5	17	Administrative	Weighted Operating Rev	78,891,476	8	720,615	720,615	14,769,914	134,912	5
6	19	Professional Services	Weighted Operating Rev	78,891,476	8	54,836		14,769,914	10,266	6
7	20	Dues, Fees, Subs & Promo	Weighted Operating Rev	78,891,476	8	8,732		14,769,914	1,635	7
8	21	Clerical & Gen Office Expenses	Weighted Operating Rev	78,891,476	8	1,229,838	1,158,439	14,769,914	230,248	8
9	24	Travel and Seminar	Weighted Operating Rev	78,891,476	8	1,720		14,769,914	322	9
10	26	Insurance-Prop.Liab.Malpractice	Weighted Operating Rev	78,891,476	8	10,039		14,769,914	1,880	10
11	27	Emp Benefit Alloc-Gen Admin	Weighted Operating Rev	78,891,476	8	493,383		14,769,914	92,370	11
12	30	Depreciation	Weighted Operating Rev	78,891,476	8	21,569		14,769,914	4,039	12
13	34	Rent-Facility & Grounds	Weighted Operating Rev	78,891,476	8	90,656		14,769,914	16,972	13
14	35	Equipment Rental	Weighted Operating Rev	78,891,476	8	37,860		14,769,914	7,088	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,327,626	\$ 2,376,524		\$ 622,992	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Avondale Estates of Elgin # 0054650 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 REX Therapeutics
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Professional Services	Therapy Revenue	6,682,538	13	\$ 142,107	\$	1,920,550	\$ 40,841	1
2	20	Fees and Subscriptions	Therapy Revenue	6,682,538	13	40,446		1,920,550	11,625	2
3	21	Clerical & General Office Exp	Therapy Revenue	6,682,538	13	125,626		1,920,550	36,105	3
4	24	Travel and Seminar	Therapy Revenue	6,682,538	13	23,337		1,920,550	6,707	4
5	25	Other Admin Staff Transp	Therapy Revenue	6,682,538	13	302		1,920,550	87	5
6	26	Insurance-Prop.Liab.Malp	Therapy Revenue	6,682,538	13	24,550		1,920,550	7,056	6
7	30	Depreciation	Therapy Revenue	6,682,538	13	3,200		1,920,550	920	7
8	32	Interest Expense	Therapy Revenue	6,682,538	13	301,155		1,920,550	86,551	8
9	34	Rent-Facility & Grounds	Therapy Revenue	6,682,538	13	6,657		1,920,550	1,913	9
10	39	Therapy Management Wages	Therapy Revenue	6,682,538	13	373,688	373,688	1,920,550	107,397	10
11	39	Therapy Consultant	Therapy Revenue	6,682,538	13	641		1,920,550	184	11
12										12
13	39	Therapy Wages	Direct	4,422,888	1	4,422,888	4,422,888	1,195,306	1,195,306	13
14	39	Allocated Employee Benefits	Total Wages	4,796,576	13	617,291		1,302,703	167,649	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,081,888	\$ 4,796,576		\$ 1,662,341	25

Facility Name & ID Number Avondale Estates of Elgin # 0054650 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Healthcare Solutions Group
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & General Office Exp	Total Charges	577,500	5	\$ 388,302	\$ 385,894	167,500	\$ 112,624	1
2	27	Emp Benefit Alloc-Gen Admin	Total Charges	577,500	5	30,734		167,500	8,914	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	TOTALS					\$ 419,036	\$ 385,894		\$ 121,538	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	SLR Healthcare		X	Working Capital		4/4/2022	3,000,000	1,410,941	4/4/2025	various	137,814		6
7													7
8													8
9	TOTAL Facility Related						\$ 3,000,000	\$ 1,410,941			\$ 137,814		9
	B. Non-Facility Related*												
10													10
11								Allocated from REX Therapeutics			86,551		11
12								Offset Interest Income			(823)		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 85,728		14
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 1,410,941			\$ 223,542		15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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 2024 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.)	2024			\$ 212,830	2
3. Under or (over) accrual (line 2 minus line 1).				\$ 212,830	3
4. Real Estate Tax accrual used for 2025 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.				\$ 212,830	7
Assessed Value from Real Estate Tax Bill:	2024	2,745,313	8		
Real Estate Tax Bill for Calendar Year:	2020	304,213	9		
	2021	241,865	10		
	2022	224,386	11		
	2023	220,710	12		
	2024	212,830	13		
This facility does not accrue for real estate taxes.					

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2024 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 Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 03-31-226-003	Long Term Care Property	\$ 212,829.52	\$ 212,829.52
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 212,829.52	\$ 212,829.52

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

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.
(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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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: 33,864 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: None 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	
Use		Square Feet		Year Acquired		Cost	
1						\$	1
2							2
3	TOTALS					\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Avondale Estates of Elgin

0054650

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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- Second Floor Generator			2017	2,639		39	68	68	547
10	New Window			2017	1,150		39	29	29	233
11	Signs			2018	14,471		15	965	965	6,996
12	Replaced Blower Motor, Belt, Drive Pulley			2021	3,012		15	201	201	904
13	Generator Repair from Water Damage			2022	5,669		20	283	283	991
14	3 New PTAC Units			2023	3,218		10	322	322	805
15	Install New Drainage Pipe to Curb and Repair Retaining Wall			2024	4,761		15	317	317	476
16	Repair Walk In Cooler			2024	3,330		15	222	222	333
17	Selcoat and Lot Mark Parking Lot			2024	5,983		15	399	399	598
18	Repair Irrigation and Chemical Dispenser Backflows			2025	3,438		15	115	115	115
19										19
20										20
21										21
22										22
23	Allocated from Premier Healthcare Management LLC.			2023	7,761		20	388	388	970
24	Allocated from Premier Healthcare Management LLC.			2024	2,996		20	150	150	225
25										25
26										26
27										27
28										28
29										29
30	Financial Statement Depreciation Expense					41,304			(41,304)	
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
SEE ACCOUNTANTS' PREPARATION REPORT

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							\$	\$	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)		\$58,428	\$41,304		\$3,459	\$(37,845)	\$13,193	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$184,274	\$	\$18,147	\$18,147	10 yrs	\$108,785	71
72	Current Year Purchases	22,103		1,105	1,105	10 yrs	1,105	72
73	Fully Depreciated Assets							73
74	Premier Healthcare Mgmt LLC/REX Therapeutics			4,421	4,421			74
75	TOTALS	\$206,377	\$	\$23,673	\$23,673		\$109,890	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$264,805	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$41,304	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$27,132	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(14,172)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$123,083	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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:Elgin-J-DEK LLP
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	\$1,556,857			3
4	Additions							4
5	Allocated from Management Co.				16,972			5
6	Allocated from REX Therapeutics				1,913			6
7	TOTAL		120		\$1,575,742			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
- N/A
N/A

9. Option to Buy:
- ☐ YES☐ NO
- Terms: N/A
- *

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: \$102,589
- Description: See Attached Schedule 14A
- (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	Facility	2022 Ford Elkhart	\$1,079.00	\$12,948	17
18					18
19	Allocated from Management Co			7,088	19
20					20
21	TOTAL		\$1,079.00	\$20,036	21

10. Effective dates of current rental agreement:

Beginning8/1/24

Ending7/31/29

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

	Fiscal Year Ending	Annual Rent
12.	7/31/2026	\$1,562,213
13.	7/31/2027	\$1,593,457
14.	7/31/2028	\$1,625,326

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

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

Facility Name:

Avondale Estates of Elgin

IDPH License ID Number:

0054650

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	108,327
Office Equipment	(7,043)
Time Clock	1,305
Total - Line 16	102,589

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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(7)	12434	hrs	\$ 479,349		\$	12,434	\$ 479,349	1
2	Licensed Speech and Language Development Therapist	39(7)	4186	hrs	161,370			4,186	161,370	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	39(2), (7)	14385	hrs	554,587		563	14,385	555,150	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			693,683		693,683	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Therapy Mgr-Allocated</u>	39(7)	1498		107,397			1,498	107,397	12
13	Other (specify): <u>Allocated Empl Benefit</u>	39(7)			167,649				167,649	13
14	TOTAL				\$ 1,470,352	\$	\$ 694,246	32,503	\$ 2,164,598	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.

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,324	\$ 21,324	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,154)	2,983,145	2,983,145	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	240,420	240,420	6
7	Other Prepaid Expenses	237,514	237,514	7
8	Accounts Receivable (owners or related parties)	2,831,488	2,831,488	8
9	Other(specify): Due from Medicare/Others	152,641	152,641	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,466,532	\$ 6,466,532	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	61,900	58,428	15
16	Equipment, at Historical Cost	358,928	206,377	16
17	Accumulated Depreciation (book methods)	(342,513)	(123,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Option Deposit	500,000	500,000	22
23	Other(specify): See Att Sch 17A	306,598	306,598	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 884,913	\$ 948,320	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,351,445	\$ 7,414,852	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,484,534	\$ 2,484,534	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,410,941	1,410,941	29
30	Accrued Salaries Payable	218,715	218,715	30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Accrued Expenses	229,536	229,536	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,343,726	\$ 4,343,726	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)	\$ 4,343,726	\$ 4,343,726	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,007,719	\$ 3,071,126	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,351,445	\$ 7,414,852	48

Facility Name:Avondale Estates of Elgin

IDPH License ID Number:0054650

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After
		Consolidation
Escrow-Insurance	80,739	80,739
Escrow Cap-Ex	216,265	216,265
Loan Origination Costs	116,621	116,621
Amortization Loan Costs	(107,027)	(107,027)
Total - Line 23		
	306,598	306,598
	306,598	306,598

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,023,378	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,023,378	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,341	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	(80,000)	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)	\$ (15,659)	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)	\$ 3,007,719	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Avondale Estates of Elgin

0054650

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 16,155,412	1
2	Discounts and Allowances for all Levels	(1,498,537)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,656,875	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,303	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 95,303	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	3,293	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,286	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,579	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	823	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 823	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,786	28
28a	See Attached Schedule 19A	166,136	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 167,922	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,926,502	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,393,856	31
32	Health Care	5,064,798	32
33	General Administration	2,963,419	33
	B. Capital Expense		
34	Ownership	2,092,106	34
	C. Ancillary Expense		
35	Special Cost Centers	3,246,339	35
36	Provider Participation Fee	101,643	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,862,161	40
41	Income before Income Taxes (line 30 minus line 40)**	64,341	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 64,341	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 243,012.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	133,628.00	45
46	MMAI-Medicaid is the Primary Payer	109,611.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,104,381.00	48
49	Medicare Part A	9,539,037.00	49
50	Other-(specify) Insurance	2,270,480.00	50
51	Other-(specify) Managed Care A	1,256,726.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,656,875	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Avondale Estates of Elgin

IDPH License ID Number:

0054650

Fiscal Year End:

12/31/2025

Schedule 19A	Amount
XVII. INCOME STATEMENT	
Line 28a- Other Income	
Quality Incentive	12,156
Prior Year Expense Adjustments	153,980
Total	166,136

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	29,762	32,131	1,531,207	47.66	3
4	Licensed Practical Nurses	22,410	24,049	1,081,069	44.95	4
5	CNAs & Orderlies	63,729	67,549	1,535,136	22.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,958	2,134	64,813	30.37	9
10	Activity Assistants	3,259	3,459	55,151	15.94	10
11	Social Service Workers	4,828	5,118	149,747	29.26	11
12	Dietician					12
13	Food Service Supervisor	2,030	2,186	72,494	33.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,153	18,297	313,507	17.13	15
16	Dishwashers					16
17	Maintenance Workers	3,721	3,974	111,455	28.05	17
18	Housekeepers	10,904	11,717	181,829	15.52	18
19	Laundry	2,003	2,109	32,458	15.39	19
20	Administrator	2,032	2,200	159,957	72.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,952	2,072	76,216	36.78	23
24	Clerical	7,691	8,280	206,933	24.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,637	2,791	64,878	23.25	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	8,388	9,039	343,550	38.01	33
34	TOTAL (lines 1 - 33)	184,457	197,105	\$ 5,980,400 *	\$ 30.34	34

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	622	\$ 32,940	L1, C3	35
36	Medical Director	Monthly	26,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,350	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	Monthly	40,661	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	622	\$ 104,951		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Avondale Estates of Elgin

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS / Care Plan Coordinator	4,311	4,650	216,854	46.64
Program Transportation	2,197	2,357	41,230	17.49
Marketing	1,880	2,032	85,466	42.06
TOTAL	8,388	9,039	343,550	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Allison Bertacchi	Administrator	0	\$ 159,957	Workers' Compensation Insurance	\$	47,760	IDPH License Fee	\$ 3,152	
				Unemployment Compensation Insurance		25,861	Advertising: Employee Recruitment	25,807	
				FICA Taxes		437,931	Health Care Worker Background Check		
				Employee Health Insurance		223,421	(Indicate # of checks performed 44)	1,569	
				Employee Meals		4,633	Patient Background Checks	7,352	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Other Employee Benefits		23,294	Reside Admissions	8,913	
							Licenses/Permits/Fees	2,272	
							Dues & Subscriptions	7,034	
							Allocated from Mgmt Co./REX	13,260	
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 159,957				PAC and Lobbying payments	()	
B. Administrative - Other							All non-allowable advertising	()	
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 734,111				\$ 69,359		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 734,111	TOTAL (agree to Schedule V, line 22, col.8)			\$ 762,900		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
See Attached	Legal	\$	59,369			\$	Out-of-State Travel	\$	
Roth & Company LLP	Accounting		22,500						
Templin Healthcare Accounting	Accounting		6,636						
Assured Managed Care, Inc	Managed Care Contract Cons		29,354				In-State Travel		
Ability Network Inc.	Data Processing		13,787						
Change Healthcare	Data Processing		741						
Claimex	Billing Consultant		1,879						
Creative Technology Solutions	Data Processing		24,996				Seminar Expense	1,612	
							Allocated from Mgmt Co./REX	7,029	
See Attached Schedule 21A			146,211				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 305,473			\$	TOTAL	\$ 8,641	

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name:

Avondale Estates of Elgin

IDPH License ID Number:

0054650

Fiscal Year End:

12/31/2025

Schedule 21A

XIX. Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
Collaborative Healthcare Urgency Group	Healthcare Emergency Preparedness	1,321
Dyatech, LLC	Benefits Consultant	375
eSolutions, Inc	Data Processing	5,147
Experian Health Inc.	Revenue Cycle Management	319
GCHMO, Inc	Managed Care Contracting Services	23,307
MatrixCare	Data Processing	4,105
Medset	Data Analysis	1,600
Microsoft	Data Processing	4,475
Paycom/Paycor	Payroll Processing	30,443
Personnel Planners	Unemployment Consultants	1,275
PointClickCare Technologies Inc	Accounting Software/Data Processing	50,806
Sage Intacct, Inc	Data Processing	9,688
SNF Metrics LLC	Data Processing	6,945
Wellsky	Data Processing	6,405
Total		146,211

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 25,324 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 101,643

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 4,633

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A
- (12)

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.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

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.

\$ N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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.