



Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC

# 0054650 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

**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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		182	14,154	14,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		182	14,154	14,336	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 32.73%**

**D. How many bed reserve days during this year were paid by the Department? \_\_\_\_\_ (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 13,066

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC # 0054650 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	242,624	5,000	27,456	275,080		275,080		275,080		1
2	Food Purchase		140,888		140,888		140,888		140,888		2
3	Housekeeping	116,223	37,847		154,070		154,070		154,070		3
4	Laundry										4
5	Heat and Other Utilities			110,599	110,599		110,599		110,599		5
6	Maintenance	67,103		72,426	139,529		139,529		139,529		6
7	Other (specify):*			9,151	9,151		9,151		9,151		7
8	<b>TOTAL General Services</b>	425,950	183,735	219,632	829,317		829,317		829,317		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,889,645	121,065	155,287	2,165,997		2,165,997		2,165,997		10
10a	Therapy		1,596	5,604	7,200		7,200		7,200		10a
11	Activities	64,510	7,245	20,896	92,651		92,651		92,651		11
12	Social Services	54,915		3,183	58,098		58,098		58,098		12
13	CNA Training										13
14	Program Transportation			12,327	12,327		12,327		12,327		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,009,070	129,906	221,297	2,360,273		2,360,273		2,360,273		16
	<b>C. General Administration</b>										
17	Administrative	125,666		415,472	541,138		541,138	(215,472)	325,666		17
18	Directors Fees										18
19	Professional Services			72,754	72,754		72,754	350	73,104		19
20	Dues, Fees, Subscriptions & Promotions			65,181	65,181		65,181	(44,500)	20,681		20
21	Clerical & General Office Expenses	168,962	25,280	165,770	360,012		360,012	(107,604)	252,408		21
22	Employee Benefits & Payroll Taxes			398,229	398,229		398,229		398,229		22
23	Inservice Training & Education			454	454		454		454		23
24	Travel and Seminar			11,468	11,468		11,468	(8,000)	3,468		24
25	Other Admin. Staff Transportation			1,430	1,430		1,430		1,430		25
26	Insurance-Prop.Liab.Malpractice			107,010	107,010		107,010		107,010		26
27	Other (specify):*			129,599	129,599		129,599		129,599		27
28	<b>TOTAL General Administration</b>	294,628	25,280	1,367,367	1,687,275		1,687,275	(375,226)	1,312,049		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,729,648	338,921	1,808,296	4,876,865		4,876,865	(375,226)	4,501,639		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
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	12,327
		12,327
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	415,472
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	53,757
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	18,997
		72,754
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	44,575
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	470
	CONTRIBUTIONS VI 20 XIX F	
	DUES & SUBSCRIPTIONS XIX F	10,368
	LICENSES & PERMITS XIX F	3,546
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	781
	PATIENT BACKGROUND CHECKS XIX F	5,441
		65,181
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,890
	EQUIPMENT REPAIR & MAINTENANCE	
	OUTSIDE CLERICAL SERVICES	136,562
	PENALTIES / OVERDRAFT CHARGES VI 18	
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	26,318
	MESSENGER SERVICE	
		165,770

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	204,658
	UNEMPLOYMENT COMPENSATION XIX D	50,401
	WORKERS COMPENSATION INSURANCE XIX D	63,638
	HOSPITALIZATION INSURANCE XIX D	64,965
	EMPLOYEE BENEFITS - OTHER XIX D	5,448
	EMPLOYEE PHYSICAL EXAMS XIX D	9,119
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
		398,229
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	454
		454
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	11,468
		11,468
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,430
		1,430
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	107,010
		107,010
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	129,599
		129,599

**GRAND TOTAL COLUMN 3 OTHER 1,808,296**

AVONDALE ESTATES OF ELGIN, LLC  
SCHEDULES  
12/31/2018

EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	140,888
LESS SALES TAX	<u>0</u>
NET FOOD	140,888

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	14,336
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	43,008

ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	43,008
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	43,008

NET FOOD	140,888
DIVIDE TOTAL MEALS/YEAR	<u>43,008</u>

COST PER MEAL	3.28
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFIC	<u><u>0</u></u>

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC

#0054650

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			45,511	45,511		45,511	(41,886)	3,625			30
31	Amortization of Pre-Op. & Org.			976	976		976		976			31
32	Interest			38,232	38,232		38,232		38,232			32
33	Real Estate Taxes					349,504	349,504		349,504			33
34	Rent-Facility & Grounds			1,370,045	1,370,045	(349,504)	1,020,541		1,020,541			34
35	Rent-Equipment & Vehicles			33,878	33,878		33,878		33,878			35
36	Other (specify):* <b>amort-comp soft</b>			9,407	9,407		9,407		9,407			36
37	<b>TOTAL Ownership</b>			1,498,049	1,498,049		1,498,049	(41,886)	1,456,163			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		568,427	1,465,659	2,034,086		2,034,086		2,034,086			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,415	73,415		73,415		73,415			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		568,427	1,539,074	2,107,501		2,107,501		2,107,501			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,729,648	907,348	4,845,419	8,482,415		8,482,415	(417,112)	8,065,303			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,886)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(44,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PG 5A	(117,371)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (203,832)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(213,280)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (213,280)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (417,112)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

ID# 0054650

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (109,371)	21	1
2	NON ALLOWABLE TRAVEL	(8,000)	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	<b>Total</b>	(117,371)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC

# 0054650

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
<b>C. General Administration</b>														
17	Administrative	0	(215,472)	0	0	0	0	0	0	0	0	0	(215,472)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	350	0	0	0	0	0	0	0	0	0	350	19
20	Fees, Subscriptions & Promotions	(44,575)	75	0	0	0	0	0	0	0	0	0	(44,500)	20
21	Clerical & General Office Expenses	(109,371)	1,767	0	0	0	0	0	0	0	0	0	(107,604)	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	(8,000)	0	0	0	0	0	0	0	0	0	0	(8,000)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(161,946)	(213,280)	0	0	0	0	0	0	0	0	0	(375,226)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(161,946)	(213,280)	0	0	0	0	0	0	0	0	0	(375,226)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC # 0054650 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(41,886)	0	0	0	0	0	0	0	0	0	0	(41,886)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(41,886)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,886)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(203,832)</b>	<b>(213,280)</b>	<b>0</b>	<b>(417,112)</b>	<b>45</b>								

**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
EREZ BAVER	99			AVONDALE	SKOKIE	CONSULTING
RIVKAH BAVER	1			CONSULTING GROUP		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 415,472	AVONDALE CONSULTING GROUP, LLC		\$	(415,472)	1
2	V	17 CONSULTING FEE				200,000	200,000	2
3	V	19 PROFESSIONAL FEES				350	350	3
4	V	20 DUES & SUBSCRIPTIONS				75	75	4
5	V	21 OFFICE EXPENSE				1,767	1,767	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		\$ 415,472			\$ 202,192	\$ * (213,280)	14

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

Facility Name & ID Number

AVONDALE ESTATES OF ELGIN, LLC

# 0054650

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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								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

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC # 0054650 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

## 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, LLC # 0054650 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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									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

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC

# 0054650

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4	LOAN COSTS	X			11/20/18	4,750	2,167	11/20/19		2,583	4							
5											5							
<b>Working Capital</b>																		
6	BUSEY BANK	X	WORKING CAPITAL	INT ONLY	11/20/18		622,879	REVOLV		30,727	6							
7	VENDORS	X								4,922	7							
8											8							
9	TOTAL Facility Related					\$ 4,750	\$ 625,046			\$ 38,232	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 4,750	\$ 625,046			\$ 38,232	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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**

**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 2017 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.)

\$                      **2**

3. Under or (over) accrual (line 2 minus line 1).

\$                      **3**

4. Real Estate Tax accrual used for 2018 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.

\$                      **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2013	<u>                    </u>	<b>8</b>
2014	<u>                    </u>	<b>9</b>
2015	<u>                    </u>	<b>10</b>
2016	<u>                    </u>	<b>11</b>
2017	<u>                    </u>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$ <u>                    </u>	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$ <u>                    </u>	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$ <u>                    </u>	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$ <u>                    </u>	<b>16</b>

**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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME AVONDALE ESTATES OF ELGIN, LLC 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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>03-31-226-003</u>	<u>NURSING HOME</u>	\$ <u>349,503.76</u>	\$ <u>349,503.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>349,503.76</u></u>	\$ <u><u>349,503.76</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: \_\_\_\_\_ 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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: 14,642 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 976 4. Dates Incurred: 2017

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	ANNUNCIATOR PANEL ON SECOND FLOOR GENERATOR	2017		2,639	68	39	68		71
10	NEW WINDOW	2017		1,150	29	39	29		30
11	SIGNS	2018		14,471	603	15	603		603
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 18,260	\$ 700		\$ 700	\$	\$ 704	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	\$ 7,308	\$ 941	\$ 731	\$ (210)	10 YRS	\$ 1,096	71
72	Current Year Purchases	43,870	43,870	2,194	(41,676)	10 YRS	2,194	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 51,178	\$ 44,811	\$ 2,925	\$ (41,886)		\$ 3,290	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										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 69,438	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,625	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (41,886)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,994	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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:		<u>120</u>	<u>8/1/17</u>	\$ <u>1,370,045</u>	<u>7</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>120</b>		\$ <b>1,370,045</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 8/1/17

Ending 7/31/24

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2019</u>	\$ <u>1,371,333</u>
13.	<u>12/31/2020</u>	\$ <u>1,398,760</u>
14.	<u>12/31/2021</u>	\$ <u>1,426,735</u>

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: \$ 33,878 Description: SEE ATTACHED

(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					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	\$		\$ 601,642	\$		\$ 601,642	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			120,234			120,234	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			743,783			743,783	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							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		568,427					568,427	13
14	<b>TOTAL</b>			\$ 568,427		\$ 1,465,659	\$		\$ 2,034,086	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.**

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 14,865	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 133,578 )	944,120		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,372		6
7	Other Prepaid Expenses	17,695		7
8	Accounts Receivable (owners or related parties)	13,361		8
9	Other(specify): <u>employee loans</u>	28		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,042,441	\$	10
	<b>B. Long-Term Assets</b>			
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	18,260		15
16	Equipment, at Historical Cost	51,178		16
17	Accumulated Depreciation (book methods)	(50,471)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	14,643		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,464)		20
21	Restricted Funds	63,000		21
22	Other Long-Term Assets (spec <u>comp software</u>	15,605		22
23	Other(specify): <u>DEFERRED LOAN COSTS</u>	2,167		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 112,918	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,155,359	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 755,424	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,350		28
29	Short-Term Notes Payable	622,879		29
30	Accrued Salaries Payable	102,622		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,338		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,502,613	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,502,613	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (347,254)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,155,359	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(217,780)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(217,780)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(173,474)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>OUT OF PERIOD EXPENSES</b>		<b>15</b>
<b>16</b>	Other (describe) <b>CAPITAL CONTRIBUTED</b>	44,000	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(129,474)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(347,254)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,308,906	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,308,906	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	35	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 35	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,308,941	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	829,317	31
32	Health Care	2,360,273	32
33	General Administration	1,687,275	33
<b>B. Capital Expense</b>			
34	Ownership	1,498,049	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,034,086	35
36	Provider Participation Fee	73,415	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,482,415	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(173,474)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (173,474)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	90,470	45
46	Medicare - Net Inpatient Revenue	7,646,547	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	571,889	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,308,906	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

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

\*\* 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.

Facility Name & ID Number AVONDALE ESTATES OF ELGIN, LLC

# 0054650

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	1,424	1,564	\$ 77,548	\$ 49.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,950	24,229	829,780	34.25	3
4	Licensed Practical Nurses	10,167	10,347	299,299	28.93	4
5	CNAs & Orderlies	31,600	32,885	500,831	15.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	40,108	19.28	9
10	Activity Assistants	2,632	2,777	24,402	8.79	10
11	Social Service Workers	1,871	1,977	54,915	27.78	11
12	Dietician					12
13	Food Service Supervisor	1,728	1,856	46,134	24.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,810	16,558	196,490	11.87	15
16	Dishwashers					16
17	Maintenance Workers	2,416	2,572	67,103	26.09	17
18	Housekeepers	10,337	10,776	116,223	10.79	18
19	Laundry					19
20	Administrator	1,928	2,008	125,666	62.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,886	7,971	168,962	21.20	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	1,724	1,873	33,719	18.00	31
32	Other Health Care: <u>nursing clerical</u>	1,625	1,731	26,986	15.59	32
33	Other(specify) <u>care plan</u>	2,535	2,665	121,482	45.58	33
34	TOTAL (lines 1 - 33)	118,593	123,869	\$ 2,729,648 *	\$ 22.04	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	\$ 24,334	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	14,436	10-3	38
39	Pharmacist Consultant	H	5,096	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		5,604	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	896	11-3	44
45	Social Service Consultant	E	3,183	12-3	45
46	Other(specify)	E			46
47	<u>MEDICARE CONSULTANT</u>	S	18,000		47
48					48
49	TOTAL (lines 35 - 48)		\$ 95,549		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	760	\$ 50,813	10-3	50
51	Licensed Practical Nurses	662	36,585	10-3	51
52	Certified Nurse Assistants/Aides	1,057	30,357	10-3	52
53	TOTAL (lines 50 - 52)	2,479	\$ 117,755		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
PATRICIA STOUTD	ADMINISTRATOR		\$ 125,666	Workers' Compensation Insurance	\$ 63,638	IDPH License Fee	\$		
	ASST ADMIN		0	Unemployment Compensation Insurance	50,401	Advertising: Employee Recruitment	470		
	OTHER ADMIN		0	FICA Taxes	204,658	Health Care Worker Background Check	781		
				Employee Health Insurance	64,965	(Indicate # of checks performed )			
				Employee Meals	0	Patient Background Checks	5,441		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0		
				EMPLOYEE BENEFITS - OTHER	5,448	MARKETING/ADV/PROMO	44,575		
				EMPLOYEE PHYSICAL EXAMS	9,119	LICENSES/DUES/SUBSCRIPTIONS	13,914		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	75		
				INSURANCE - EXECUTIVE LIFE	0	TRUST/FRANCHISE/CONTRIB/ETC	0		
						Less: Public Relations Expense	( 0 )		
						Non-allowable advertising	(44,575)		
						Yellow page advertising	( 0 )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,666	INSURANCE - EXECUTIVE LIFE VI 21	0				
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 398,229	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,681		
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			\$ 415,472			\$	Out-of-State Travel	\$	
							In-State Travel	11,468	
							NON ALLOW	(8,000)	
							Seminar Expense	0	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 415,472	TOTAL		\$	TOTAL	\$ 3,468	
C. Professional Services									
Vendor/Payee	Type		Amount						
			\$						
SEE LEGAL SCHEDULE ATTACHED			72,754						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 72,754						

\* Attach copy of IMRF notifications

\*\*See instructions.

AVONDALE ESTATES OF ELGIN, LLC  
LEGAL EXPENSES  
12/31/2018

DATE	FIRM	PURPOSE	COST
10/16/2018	NIXON PEABODY, LLP	IDPH APPEAL	3,000.00
10/16/2018	RVG COMMERCIAL	REAL ESTATE TAX REDUCTION, appraisal	3,900.00
11/6/2018	NEAL, GERBER & EISENBERG LLP	EMPLOYMENT PRACTISES	2,854.80
12/14/2018	NEAL, GERBER & EISENBERG LLP	EMPLOYMENT PRACTISES	1,427.40
	FIRST AMERICAN TITLE INSURANCE COMPANY NATIONAL COMMERCIAL		
12/18/2018	SERVICES	This was related to our intial Leasing of the facility	64.50
		TOTAL LEGAL FEES	11,246.70

Facility Name &amp; ID Number AVONDALE ESTATES OF ELGIN, LLC

# 0054650

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,415  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees