

		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: 0057455 Facility Name: Abbington Vlge Nrsg Rhb Ctr Address: 31 West Central Roselle 60172 County: DuPage Telephone Number: 630-894-5058 Fax # 630-894-5070 HFS ID Number: Date of Initial License for Current Owners: 07/01/2022 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Mendel S Schneider Telephone Number: 847-933-1274 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 01/01/2025 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) (Type or Print Name) (Title) Paid Preparer (Signed) See Accountant's Report Attached (Print Name and Title) (Firm Name & Address) Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076 (Telephone) 847-933-1274 Fax # 847-933-1283 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630
--	---

Facility Name & ID Number Abbington Vlge Nrsg Rhb Ctr # 0057455 Report Period Beginning: 01/01/2025 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	<u>22</u>	Skilled (SNF)	<u>22</u>	<u>8,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>82</u>	TOTALS	<u>82</u>	<u>29,930</u>	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	4,022	9,976	2,487		2,086	1,177	1,173	20,921	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,022	9,976	2,487		2,086	1,177	1,173	20,921	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 69.90%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

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

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

I. On what date did you start providing long term care at this location? Date started 07/01/22

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 07/01/22 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 22

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Abbington Vlge Nrsg Rhb Ctr # 0057455 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	406,334	30,821	10,865	448,020		448,020		448,020			1
2	Food Purchase		211,190		211,190		211,190	(1,286)	209,904			2
3	Housekeeping	181,483	19,197	39,006	239,686		239,686		239,686			3
4	Laundry		67,729		67,729		67,729		67,729			4
5	Heat and Other Utilities			90,518	90,518		90,518	1,875	92,393			5
6	Maintenance	88,144		84,219	172,363		172,363	3,195	175,558			6
7	Other (specify):*											7
8	TOTAL General Services	675,961	328,937	224,608	1,229,506		1,229,506	3,784	1,233,290			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,482,777	205,145	184,330	2,872,252		2,872,252		2,872,252			10
10a	Therapy											10a
11	Activities	93,003	5,605		98,608		98,608		98,608			11
12	Social Services	55,844	1,365		57,209		57,209		57,209			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,631,624	212,115	202,330	3,046,069		3,046,069		3,046,069			16
	C. General Administration											
17	Administrative	180,357			180,357		180,357		180,357			17
18	Directors Fees											18
19	Professional Services			91,286	91,286		91,286	66,668	157,954			19
20	Dues, Fees, Subscriptions & Promotions			42,688	42,688		42,688	(8,148)	34,540			20
21	Clerical & General Office Expenses	281,279	81,885	89,417	452,581		452,581	63,176	515,757			21
22	Employee Benefits & Payroll Taxes			520,381	520,381		520,381		520,381			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,588	1,588		1,588		1,588			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			376,736	376,736		376,736	537	377,273			26
27	Other (specify):* Allocated Benefits							14,386	14,386			27
28	TOTAL General Administration	461,636	81,885	1,122,096	1,665,617		1,665,617	136,619	1,802,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,769,221	622,937	1,549,034	5,941,192		5,941,192	140,403	6,081,595			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 (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			21,248	21,248		21,248	141,100	162,348			30
31	Amortization of Pre-Op. & Org.							146,545	146,545			31
32	Interest											32
33	Real Estate Taxes							45,721	45,721			33
34	Rent-Facility & Grounds			40,425	40,425		40,425	(38,472)	1,953			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			164,296	164,296		164,296	(164,296)				36
37	TOTAL Ownership			225,969	225,969		225,969	130,598	356,567			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,590	389,854	483,444		483,444		483,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			339,853	339,853		339,853		339,853			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		93,590	729,707	823,297		823,297		823,297			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,769,221	716,527	2,504,710	6,990,458		6,990,458	271,001	7,261,459			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	131,565	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	(1,286)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,768)	21		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	(164,296)	36		24
25	Fund Raising, Advertising and Promotional	(3,392)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (39,177)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	314,934		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 314,934		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 275,757		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (4,756)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,756)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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	34	Rent	\$ 40,425	Abbington Village Property LLC		\$	(40,425)	1
2	V	33	Real Estate Taxes		Abbington Village Property LLC		45,721	45,721	2
3	V	30	Depreciation		Abbington Village Property LLC		9,535	9,535	3
4	V	31	Amortization		Abbington Village Property LLC		146,545	146,545	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 40,425			\$ 201,801	\$ * 161,376	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	21	Office	\$	Jade Financial Services		\$ 18,109	\$ 18,109	15
16	V	19	Professional Fees		Jade Financial Services		66,668	66,668	16
17	V	5	Utilities		Jade Financial Services		1,875	1,875	17
18	V	6	Repairs & Maintenance		Jade Financial Services		3,195	3,195	18
19	V	34	Rent		Jade Financial Services		1,953	1,953	19
20	V	21	Clerical Wages		Jade Financial Services		46,835	46,835	20
21	V	27	Allocated Benefits		Jade Financial Services		14,386	14,386	21
22	V	26	Insurance		Jade Financial Services		537	537	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			\$			\$ 153,558	\$ * 153,558	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Abbington Vlge Nrsg Rhb Ctr								
ID#					0057455			
Report Period Beginning:					01/01/2025			
Ending:					12/31/2025			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee		Building Co.	Management
-Owners of companies must be listed instead of company names.					Ownership		Ownership	Co./Home Office
-Names of trust beneficiaries must be listed.					Percentage		Percentage	Ownership
First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage	Percentage
1	Jake	0	Mashiach	Chicago	IL	23.33000		1
2	Yechiel	0	Mashiach	Lincolnwood	IL	23.33000		2
3	Rhonda	0	Mashiach	Lincolnwood	IL	10.00000		3
4	Rita	0	Lipshitz	Skokie	IL	10.00000		4
5	Atied Associates, LLC	0	0	0	0	0.00000		5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000		6
7	Beneficiaries	0	0	0	0	0.00000		7
8	Rebecca	0	Rudolph	Evanston	IL	0.38469		8
9	Michael	0	Rudolph	Evanston	IL	0.38469		9
10	Zahava	0	Vales	Evanston	IL	0.38469		10
11	Raban	0	Vales	Evanston	IL	0.38469		11
12	Natan	0	Vales	Deerfield	IL	0.38469		12
13	Amidei	0	Vales	Deerfield	IL	0.38469		13
14	Cary	0	Silvers	Evanston	IL	0.38469		14
15	Jonathan	0	Silvers	Highland Park	IL	0.38469		15
16	Jacob	0	Silvers	Highland Park	IL	0.38469		16
17	Noam	0	Rothner	Teaneck	NJ	0.38469		17
18	Yonit	0	Rothner	Teaneck	NJ	0.38469		18
19	Hanna	0	Levine	Skokie	IL	0.38469		19
20	Nathan	0	Levine	Evanston	IL	0.38469		20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000		21
22	Beneficiaries	0	0	0	0	0.00000		22
23	Melisa	0	Rothner	Skokie	IL	1.25025		23
24	Daniel	0	Rothner	Teaneck	NJ	1.25025		24
25	William	0	Rothner	Skokie	IL	1.25025		25
26	Rachel	0	Rothner	Beachwood	OH	1.25025		26
27	0	0	0	0	0	0.00000		27
28	Daniel Rothner Accumu	0	0	0	0	0.00000		28
29	Beneficiaries	0	0	0	0	0.00000		29
30	Daniel	0	Rothner	Teaneck	NJ	1.66700		30
31	William Rothner Accumu	0	0	0	0	0.00000		31
32	Beneficiaries	0	0	0	0	0.00000		32
33	William	0	Rothner	Skokie	IL	1.66700		33
34	Melisa Rothner Accumu	0	0	0	0	0.00000		34
35	Beneficiaries	0	0	0	0	0.00000		35
36	Melisa	0	Rothner	Skokie	IL	1.66700		36
37	Rachel Rothner Accumu	0	0	0	0	0.00000		37
38	Rachel	0	Rothner	Beachwood	OH	1.66700		38
39	Adam Vales Accumulati	0	0	0	0	0.00000		39
40	Adam	0	Vales	Deerfield	IL	1.66700		40
41	Kathryn Vales Accumul	0	0	0	0	0.00000		41
42	kathryn	0	Vales	Highland park	IL	1.66700		42
43	Kimberly Vales Accumu	0	0	0	0	0.00000		43
44	Kimberly	0	Vales	Highland Park	IL	1.66700		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								70
71								71
72								72
73								73
74								74
75								75

Facility Name & ID Number

Abbington Vlge Nrsg Rhb Ctr

0057455

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CEN	Joliet	Jade Financial Service	Skokie, IL	Mgmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis	Abbington Property	Roselle, IL	Bldg Rental	2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION C	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATIO	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION C	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITA	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER L	Tucson				8
9	ELMWOOD NURSING & REHABILITATION	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER I	Crestwood	DEVON GABLES REHABILITATION CENTE	Tucson				10
11	KENSINGTON NURSING AND REHABILITA	Chicago	ST. JAMES WELLNESS REHAB & VILLAS L	Crete				11
12	ABBINGTON VILLAGE NURSING AND REH	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILIT	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHAB	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	westwood Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION C	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION C	Rushville	RUSHVILLE NURSING REHABILITATION C	Rushville				20
21	NEIGHBORS REHABILITATION CENTER L	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER I	Champaign	PARK VILLA NURSING & REHABILITATIO	Palos Heights				22
23	Sheridan Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REH	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Wheaton Village & Nursing Center	Wheaton	UNIVERSITY REHABILITATION CENTER C	Urbana				25
26			PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27			BURBANK REHABILITATION CENTER LLC	Burbank				27
28			COUNTRYSIDE NURSING & REHABILITAT	Dolton				28
29								29
30								30

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									\$		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	\$		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

Ending: 2/31/2025

()

	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	Office	Number of Beds	1,231	10	\$ 271,852	\$	82	\$ 18,109	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		82	66,668	2
3	5	Utilities	Number of Beds	1,231	10	28,149		82	1,875	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		82	3,195	4
5	34	Rent	Number of Beds	1,231	10	29,319		82	1,953	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	82	46,835	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		82	14,386	7
8	26	Insurance	Number of Beds	1,231	10	8,068		82	537	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					\$ 2,305,240	\$ 703,094		\$ 153,558	25

Ending: 2/31/2025

Fax Number

	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						\$	\$		\$	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

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													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	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.)

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,478 B. General Construction Type: Exterior Brick Frame Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO 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? (X) YES NO
If so, please complete the following:

1. Total Amount Incurred: 1,325,913 2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 146,545 4. Dates Incurred: 07/01/22

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	Facility			2022	\$	105,675	1
2							2
3	TOTALS				\$	105,675	3

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)		\$3,753,842	\$30,783		\$149,793	\$119,010	\$816,093	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	\$ 125,550	\$	\$ 12,555	\$ 12,555	10	\$ 95,531	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 125,550	\$	\$ 12,555	\$ 12,555		\$ 95,531	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)	\$ 3,985,067	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,783	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,348	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 131,565	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 911,624	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Jade				1,953			6
7	TOTAL				\$ 1,953			7

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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	TOTAL		\$	\$	21

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

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

\$

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 165,702	\$		\$ 165,702	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,831			30,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			193,321			193,321	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				72,789		72,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-3					20,801		20,801	12
13	Other (specify):									13
14	TOTAL			\$		\$ 389,854	\$ 93,590		\$ 483,444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,209,359)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,209,359)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,211)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (89,211)	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)	\$ (3,298,570)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Abbington Vlge Nrsg Rhb Ctr

0057455

Report Period Beginning: 01/01/2025

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	\$ 6,879,988	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,879,988	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	21,225	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,225	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,901,247	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,229,506	31
32	Health Care	3,046,069	32
33	General Administration	1,665,617	33
	B. Capital Expense		
34	Ownership	225,969	34
	C. Ancillary Expense		
35	Special Cost Centers	483,444	35
36	Provider Participation Fee	339,853	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,990,458	40
41	Income before Income Taxes (line 30 minus line 40)**	(89,211)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (89,211)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,074,579.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,841,184.00	45
46	MMAI-Medicaid is the Primary Payer	656,410.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	510,563.00	48
49	Medicare Part A	863,170.00	49
50	Other-(specify) Medicare-B	235,893.00	50
51	Other-(specify) Medicare Advantage	698,189.00	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)	\$ 6,879,988	56

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	1,864	2,158	\$ 138,487	\$ 64.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,205	23,450	1,110,074	47.34	3
4	Licensed Practical Nurses	3,450	3,811	165,609	43.46	4
5	CNAs & Orderlies	30,989	34,168	876,596	25.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,020	1,132	24,099	21.29	9
10	Activity Assistants	3,436	3,705	68,904	18.60	10
11	Social Service Workers	1,699	1,834	55,844	30.45	11
12	Dietician					12
13	Food Service Supervisor	1,757	1,863	53,048	28.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,682	17,217	353,286	20.52	15
16	Dishwashers					16
17	Maintenance Workers	2,462	2,681	88,144	32.88	17
18	Housekeepers	8,328	9,176	181,483	19.78	18
19	Laundry					19
20	Administrator	2,048	2,080	180,357	86.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,086	6,549	281,279	42.95	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	2,269	2,401	65,085	27.11	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,353	2,473	126,926	51.32	33
34	TOTAL (lines 1 - 33)	104,648	114,698	\$ 3,769,221 *	\$ 32.86	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	Monthly	\$ 10,865	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,903	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,768		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	214	\$ 12,816	10-3	50
51	Licensed Practical Nurses	148	8,150	10-3	51
52	Certified Nurse Assistants/Aides	4,527	158,461	10-3	52
53	TOTAL (lines 50 - 52)	4,889	\$ 179,427		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberAbbington Vlge Nrsg Rhb Ctr# 0057455Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Nikki Dinsmore

Administrator

0

\$ 180,357

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 180,357

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Mendel Schneider CPA

Accounting

\$ 10,400

Elizabeth Nash

Clin Reimb

28,800

Guided Care

Case Mgmt

21,645

Cozeen Oconnor

Legal

2,992

Much Shelist

Legal

840

Mccabe Kirshner

Legal

1,735

Sher LLP

Legal

9,509

Goodniki LLP

Legal

4,189

Breakaway Advisors

Medicare Cons

11,176

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 91,286

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 42,119

Unemployment Compensation Insurance

43,761

FICA Taxes

281,908

Employee Health Insurance

152,593

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

TOTAL (agree to Schedule V, line 22, col.8)

\$ 520,381

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

6,802

Health Care Worker Background Check

3,889

(Indicate # of checks performed)

Patient Background Checks

1,541

Association Dues (total from pg 22, #4)

14,268

Netsmart

3,828

RADAR

2,136

Various

4,842

Less: Public Relations Expense

()

PAC and Lobbying payments

(4,756)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 34,540

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Various

1,588

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,588

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (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

HEALTH CARE COUNCIL OF IL (HCCI)

Amount

9,512

9,512

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.

HEALTH CARE COUNCIL OF IL (HCCI)

4,756

4,756

Total

(4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

14,268

14,268

Total

(5)

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

\$ 35,273

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.

\$ 339,853

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.

\$

Has any meal income been offset against
related costs?

Indicate the amount.

\$

(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?

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?

d. Have vehicle usage logs been maintained?

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

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

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$

(13)

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

No

Firm Name:

(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.