

		FOR BHF USE						

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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: <u>0008409</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Alton Memorial Rehab Therapy</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>1251 College Avenue</u> <u>Alton</u> <u>62002</u> Number City Zip Code																											
County: <u>Madison</u>																											
Telephone Number: <u>(618) 463-7330</u> Fax # <u>(618) 463-7850</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>12/30/1966</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave. Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																									
☒ Charitable Corp.	☐ Individual	☐ State																									
☐ Trust	☐ Partnership	☐ County																									
IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____																									
	☐ "Sub-S" Corp.	_____																									
	☐ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberAlton Memorial Rehab Therapy# 0008409Report Period Beginning: 1/1/2025Ending: 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

1234

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	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	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

123456789

	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	
8	SNF	2,372				3,030	4,196	6,902	16,500	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,372				3,030	4,196	6,902	16,500	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)70.63%

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 NOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YES NOX

I. On what date did you start providing long term care at this location?Date started12/30/1966

J. Was the facility purchased or leased after January 1, 1978?YES Date NOX

K. Was the facility certified for Medicare during the reporting year?YESXNO If YES, enter certified beds. number of certified beds64

Medicare IntermediaryWisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUALXMODIFIEDCASH*CASH*

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

Tax Year:12/31/2025Fiscal Year:12/31/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary		174	420,700	420,874		420,874	11,049	431,923		1
2	Food Purchase		420,912		420,912		420,912	7,288	428,200		2
3	Housekeeping	194,116	18,279	5,115	217,510		217,510		217,510		3
4	Laundry		139	52,925	53,064		53,064	(3,112)	49,952		4
5	Heat and Other Utilities			171,722	171,722		171,722		171,722		5
6	Maintenance	108,120	42,023	141,255	291,398		291,398		291,398		6
7	Other (specify):*										7
8	TOTAL General Services	302,236	481,527	791,717	1,575,480		1,575,480	15,225	1,590,705		8
	B. Health Care and Programs										
9	Medical Director					20,900	20,900		20,900		9
10	Nursing and Medical Records	2,750,056	129,601	187,414	3,067,071		3,067,071		3,067,071		10
10a	Therapy										10a
11	Activities	92,300	1,156	1,225	94,681	1,814	96,495		96,495		11
12	Social Services	68,337	84		68,421	1,814	70,235		70,235		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,910,693	130,841	188,639	3,230,173	24,528	3,254,701		3,254,701		16
	C. General Administration										
17	Administrative	125,569			125,569		125,569		125,569		17
18	Directors Fees										18
19	Professional Services			753,056	753,056	(27,713)	725,343		725,343		19
20	Dues, Fees, Subscriptions & Promotions			79,312	79,312	3,185	82,497	(53,661)	28,836		20
21	Clerical & General Office Expenses	403,739	21,458	49,331	474,528		474,528	(5,666)	468,862		21
22	Employee Benefits & Payroll Taxes			860,212	860,212		860,212		860,212		22
23	Inservice Training & Education			1,560	1,560		1,560		1,560		23
24	Travel and Seminar			4,322	4,322		4,322		4,322		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			212,398	212,398		212,398		212,398		26
27	Other (specify):*										27
28	TOTAL General Administration	529,308	21,458	1,960,191	2,510,957	(24,528)	2,486,429	(59,327)	2,427,102		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,742,237	633,826	2,940,547	7,316,610		7,316,610	(44,102)	7,272,508		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			66,884	66,884		66,884		66,884		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			82,753	82,753		82,753		82,753		35
36	Other (specify):*										36
37	TOTAL Ownership			149,637	149,637		149,637		149,637		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		472,506	741,899	1,214,405		1,214,405		1,214,405		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			87,595	87,595		87,595		87,595		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		472,506	829,494	1,302,000		1,302,000		1,302,000		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,742,237	1,106,332	3,919,678	8,768,247		8,768,247	(44,102)	8,724,145		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				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	(41,747)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(24,417)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,164)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	22,062		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,062		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (44,102)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0008409

1/1/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	0	20	2
3	Public Relations	(11,914)	20	3
4	Transcript Fee	(330)	21	4
5	Vending Income	(3,725)	2	5
6	Misc. Income	(4,856)	21	6
7	Income from Credit Card Fees	(284)	21	7
8	Lost Personal Property	(196)	21	8
9	Laundry Income	(3,112)	4	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,417)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See BOD at "Ownership-1"		Memorial Care Center	Belleville, IL			

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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary Services	\$ 427,043	BJC - Alton Memorial Hospital		\$ 438,092	\$ 11,049	1
2	V	2	Food	427,044	BJC - Alton Memorial Hospital		438,057	11,013	2
3	V	3	IT	4,666	BJC Healthcare	100.00%	4,666		3
4	V	4	Ancillary Services	609	BJC Healthcare	100.00%	609		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			\$ 859,362			\$ 881,424	\$ * 22,062	14

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

Report Period Beginning:

Ending:

ID#

0008409

1/1/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

			Place of Residence		Operator/Licensee	Building Co.	Management	
	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Co./Home Office Ownership Percentage
1	Gary		Ayres					1
2	Steven		Thompson					2
3	Shelia		Goins					3
4	David		Braasch					4
5	Debbie		Turpin					5
6	April		Becker					6
7	Susan		Koesterer					7
8	Chuck		Robb					8
9	Timothy		Childers					9
10	Melissa		Erker					10
11	Craig		Harms					11
12	Ebony		Huddleston					12
13	Kenneth		Loy					13
14	Joan		Magruder					14
15	Tanya		Patton					15
16	Matthew		Schrimpf					16
17	Michael		Tchoukaleff					17
18	Geoffrey		Turner					18
19	Kenneth		Trzaska					19
20								20
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75								75

VII. RELATED PARTIES

A. (Continued)

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
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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	N/A								\$		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.

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 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	N/A					\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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	N/A						\$	\$			\$		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.)

B. Real Estate Taxes

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021	(20,941)	10
	2022		11
	2023		12
	2024		13

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alton Memorial Rehab Therapy COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0008409

CONTACT PERSON REGARDING THIS REPORT Roger Byrne

TELEPHONE (314) 800-1956 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>23-1-07-12-12-201-009</u>	<u>PT SE NE PART SW NE</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

36,234

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒ If YES, please indicate name of the facility.

IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	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			1966	1966	\$433,793	\$	40	\$		\$433,793	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1966 ADDITIONS		1966		\$24,918		Various			\$24,918	9
10	1968 ADDITIONS		1968		1,049		Various			1,049	10
11	1980 ADDITIONS		1980		3,880		Various			3,880	11
12	1981 ADDITIONS		1981		40,133		Various			40,133	12
13	1983 ADDITIONS		1983		8,868		Various			8,868	13
14	1985 ADDITIONS		1985		7,208		Various			7,208	14
15	1990 ADDITIONS		1990		27,998		Various			27,998	15
16	1991 ADDITIONS		1991		12,575		Various			12,575	16
17	1992 ADDITIONS		1992		30,291		Various			30,291	17
18	1993 ADDITIONS		1993		68,589		Various			68,589	18
19	1994 ADDITIONS		1994		12,883		Various			12,883	19
20	1995 ADDITIONS		1995		82,542		Various			82,542	20
21	1996 ADDITIONS		1996		9,373		Various			9,373	21
22	1997 ADDITIONS		1997		39,454		Various			39,454	22
23	1998 ADDITIONS		1998		28,092		Various			28,092	23
24	1999 ADDITIONS		1999		16,822		Various			16,822	24
25	2001 ADDITIONS		2001		193,922	7,757	Various	7,757		191,337	25
26	2003 ADDITIONS		2003		197,646		Various			197,646	26
27	2004 ADDITIONS		2004		189,766		Various			189,766	27
28	2005 ADDITIONS		2005		62,559	146	Various	146		61,926	28
29	2007 ADDITIONS		2007		12,156		Various			12,156	29
30	2008 ADDITIONS		2008		35,700		Various			35,700	30
31	2009 ADDITIONS		2009		66,272		Various			66,272	31
32	2011 ADDITIONS		2011		5,500		Various			5,500	32
33	2012 ADDITIONS		2012		23,597		10			23,597	33
34	HVAC		2013		12,800		10			12,800	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2014 Additions	2014	\$ 46,406	\$	Various	\$		\$ 46,406	37
38	2015 Additions	2015	100,183	5,559	Various	5,559		76,739	38
39	2016 Additions	2016	11,796	590	Various	590		5,603	39
40	2017 Additions	2017	73,775	6,925	Various	6,925		58,863	40
41	2018 Additions	2018	76,311	6,366	Various	6,366		45,263	41
42	Pump & Motor Assembly	2020	3,942	493	8	493		2,710	42
43	AC Units (5)	2021	7,245	4,344	5	4,344		19,547	43
44	Booster Heater - Replacement	2021	3,165	1,449	10	1,449		6,521	44
45	Parking Lot and Stripping - Asphalt	2021	34,750	316	8	316		1,424	45
46	Hot Water Loop Project	2022	19,674	1,312	30	1,312		4,591	46
47	DRAIN REPLACEMENT - KITCHEN	2024	5,203	2,200	25	2,200		3,300	47
48	NURSE CALL UPGRADE R5000 RI	2024	22,000	617	10	617		926	48
49	MAGNETIC DOOR LOCK/HOLDER - WANDERGUARD	2024	6,172	208	10	208		312	49
50	CAP PROJ 25-2022-23-006 NURSING STATION X 2 REPLACE	2024	21,647	1,774	15	1,774		2,496	50
51	CAP PROJ 25-2024-25-002 ENTRANCE DOOR	2024	30,080	3,008	10	3,008		4,512	51
52	DRAIN REPLACEMENT - DISH MACHINE	2025	5,468	109	25	109		109	52
53	CAP PROJ 25-2022-23-006 NURSING STATION X 2 REPLACE	2025	9,951	2,496	15	2,496		2,496	53
54	CAP PROJ 25-2024-25-005 HVAC SPLIT SYSTEM - MECHANICAL	2025	30,765	3,077	5	3,077		3,077	54
55	CAP PROJ 25-2024-25-003 WINDOWS (40)	2025	82,758	2,069	20	2,069		2,069	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)		\$ 2,739,676	\$ 50,815		\$ 50,815	\$	\$ 2,432,132	70

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

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	\$150,679	\$16,069	\$16,069	\$	Various	\$65,756	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	640,216				Various	640,216	73
74								74
75	TOTALS	\$790,895	\$16,069	\$16,069	\$		\$705,972	75

D. Vehicle Costs. (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	2011 Ford E450	2011	\$ 51,305	\$	\$	\$	10	\$ 51,305	76
77										77
78										78
79										79
80	TOTALS			\$ 51,305	\$	\$	\$		\$ 51,305	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,581,876	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,884	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,884	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,189,409	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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: \$ 82,753 Description: Nursing equipment, copier, and storage
- ☐ YES☒ NO
- (Attach a schedule detailing the breakdown of movable equipment)

	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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
Fiscal Year EndingAnnual Rent
12. /2026 \$
13. /2027 \$
14. /2028 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		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		V39-2 & V39-3	hrs	\$	4,920	\$ 316,438	\$ 1,380	4,920	\$ 317,818	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		2,327	89,859		2,327	89,859	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	V39-2 & V39-3	hrs		5,324	300,805	2,039	5,324	302,844	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	V39-2	# of prescripts				469,087		469,087	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Radiology/Laboratory</u>	V39-3				34,797			34,797	12	
13	Other (specify): _____									13	
14	TOTAL			\$	12,571	\$ 741,899	\$ 472,506	12,571	\$ 1,214,405	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 108,225	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 380,325)	1,324,696		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,446		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,439,367	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,081,727		14
15	Leasehold Improvements, at Historical Cost	285,061		15
16	Equipment, at Historical Cost	2,215,088		16
17	Accumulated Depreciation (book methods)	(3,189,409)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 392,467	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,831,834	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 257,428	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	(3,161,279)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (2,903,851)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,903,851)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,735,685	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,831,834	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,251,188	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,251,188	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	18,249	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) Additional Paid In Capital BJC	(533,752)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (515,503)	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)	\$ 4,735,685	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,816,624	1
2	Discounts and Allowances for all Levels	(2,210,433)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,606,191	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,390,875	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,390,875	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	559,358	17
18	Sale of Supplies to Non-Patients	141,736	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,112	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 704,206	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	85,224	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 85,224	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,786,496	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,575,480	31
32	Health Care	3,230,173	32
33	General Administration	2,510,957	33
B. Capital Expense			
34	Ownership	149,637	34
C. Ancillary Expense			
35	Special Cost Centers	1,214,405	35
36	Provider Participation Fee	87,595	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,768,247	40
41	Income before Income Taxes (line 30 minus line 40)**	18,249	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 18,249	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 497,510.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	429,335.00	48
49	Medicare Part A	1,375,855.00	49
50	Other-(specify) Managed Care	2,303,491.00	50
51	Other-(specify)		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)	\$ 4,606,191	56

		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	8,364	8,364	\$ 441,151	\$ 52.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,692	5,692	291,600	51.23	3
4	Licensed Practical Nurses	20,080	20,080	905,794	45.11	4
5	CNAs & Orderlies	39,126	39,126	1,092,003	27.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,782	3,782	92,300	24.41	10
11	Social Service Workers	2,117	2,117	68,337	32.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,761	3,761	108,120	28.75	17
18	Housekeepers	9,495	9,495	194,116	20.44	18
19	Laundry					19
20	Administrator	1,984	1,984	125,569	63.29	20
21	Assistant Administrator					21
22	Other Administrative	971	971	19,508	20.09	22
23	Office Manager					23
24	Clerical	11,963	11,963	403,739	33.75	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,335	107,335	\$ 3,742,237 *	\$ 34.87	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		\$		35
36	Medical Director	Monthly	20,900	V10-4	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,814	V11-4	44
45	Social Service Consultant		1,814	V12-4	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,528		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	909	\$ 77,223	V10-3	50
51	Licensed Practical Nurses	0	0	V10-3	51
52	Certified Nurse Assistants/Aides	1,541	54,535	V10-3	52
53	TOTAL (lines 50 - 52)	2,450	\$ 131,758		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
Kathryn Liszewski	Administrator	0	\$ 125,569	Workers' Compensation Insurance	\$	239,581	IDPH License Fee	\$ 3,185
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	41,747
				FICA Taxes		231,778	Health Care Worker Background Check	
				Employee Health Insurance		253,472	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	10,000
				Medicare Taxes		54,206	Public Relations	11,914
				TSA Pension		50,629	Subscriptions/Dues	10,654
				Life and Disability		20,465	Licenses & Permits	4,997
				Other Incentives		10,081		
							Less: Public Relations Expense	(53,661)
							PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$		125,569	TOTAL (agree to Sch. V, line 20, col. 8)	
							\$	28,836
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
			\$	N/A		\$	Out-of-State Travel	\$
							In-State Travel	2,587
							Seminar Expense	1,735
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$			(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	\$ 4,322
Vendor/Payee	Type		Amount					
National Datacare Corporation	Business Office		\$ 15,129					
Bethesda Health Group	Management Fee		517,085					
Bethesda Health Group	Technology Services		153,878					
Accurate Biometrics	Fingerprinting/Background Ch		2,051					
Alton Burglar Alarm	Security System		60					
BJC	IT		4,666					
CEP America	Medical Director		20,900					
IL State Police	Background Checks		5,967					
IL Dept of Public Health	License Fee		3,185					
Outcome Services of IL	Social Svs/Activities		3,628					
Iron Mountain/Shred-IT USA	Record Storage/Shredding		3,107					
Various	Professional Services		23,400					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$		753,056		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID NumberAlton Memorial Rehab Therapy

STATE OF ILLINOIS

#0008409

Report Period Beginning:1/1/2025

Ending:12/31/2025

Page 22

XX. GENERAL INFORMATION:

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

No

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

Association Name

Amount

LEADING AGE

10,000

10,000Total

(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

LEADING AGE

Total

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

LEADING AGE

10,000

10,000Total

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

\$23,911

Line10

(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.

\$87,595

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.

\$

Yes

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?

No

If YES, please indicate the amount of income earned from such a
program during this reporting period.

\$N/A

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

0

d. Have vehicle usage logs been maintained?

N/A

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

Yes

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

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

(13)Has an audit been performed by an independent certified public accounting firm

Firm Name:

Yes

(14)Have all costs which do not relate to the provision of long term care been adjusted out
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: