

		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: 0039636

Facility Name: Autumn Meadows of Cahokia

Address: 2 Annable Court Cahokia 62206

County: Saint Clair

Telephone Number: (618) 332-0114 Fax # (618) 332-1043

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

X "Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name: Amanda Springborn Telephone Number: (314) 925-3838

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)

(Signed)

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone)

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

Autumn Meadows of Cahokia

0039636

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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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	5,926	19,292	543	-	66	968	5,241	32,036	8	
9	SNF/PED									9	
10	ICF									10	
11	ICF/DD									11	
12	SC									12	
13	DD 16 OR LESS									13	
14	TOTALS	5,926	19,292	543		66	968	5,241	32,036	14	

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

58.51%

D. How many bed reserve days during this year were paid by the Department?

None (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 ☐

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 7/1/1994

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

YES ☒ Date 7/1/1994 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐

If YES, enter certified beds.

number of certified beds 150

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

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

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

Facility Name & ID Number		Autumn Meadows of Cahokia				STATE OF ILLINOIS		# 0039636		Report Period Beginning:		01/01/2025		Ending:		Page 3	
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	304,571	23,387	9,691	337,649		337,649		337,649								1
2	Food Purchase		253,515		253,515		253,515		253,515								2
3	Housekeeping	213,531	45,434		258,965		258,965		258,965								3
4	Laundry	132,796	17,958		150,754		150,754		150,754								4
5	Heat and Other Utilities			198,179	198,179		198,179		198,179								5
6	Maintenance	124,602		163,605	288,207		288,207	4,038	292,245								6
7	Other (specify):*																7
8	TOTAL General Services	775,500	340,294	371,475	1,487,269		1,487,269	4,038	1,491,307								8
	B. Health Care and Programs																
9	Medical Director			27,832	27,832		27,832		27,832								9
10	Nursing and Medical Records	3,249,400	150,886	321,841	3,722,127		3,722,127	38,857	3,760,984								10
10a	Therapy																10a
11	Activities	75,611			75,611		75,611		75,611								11
12	Social Services	129,069			129,069		129,069		129,069								12
13	CNA Training																13
14	Program Transportation																14
15	Other (specify):*																15
16	TOTAL Health Care and Programs	3,454,080	150,886	349,673	3,954,639		3,954,639	38,857	3,993,496								16
	C. General Administration																
17	Administrative	127,413		120,000	247,413		247,413	(27,500)	219,913								17
18	Directors Fees																18
19	Professional Services			790,531	790,531		790,531	(114,577)	675,954								19
20	Dues, Fees, Subscriptions & Promotions			98,654	98,654		98,654	(13,050)	85,604								20
21	Clerical & General Office Expenses	254,609	18,075	15,535	288,219		288,219	(2,067)	286,152								21
22	Employee Benefits & Payroll Taxes			586,266	586,266		586,266		586,266								22
23	Inservice Training & Education																23
24	Travel and Seminar			11,725	11,725		11,725		11,725								24
25	Other Admin. Staff Transportation			7,023	7,023		7,023		7,023								25
26	Insurance-Prop.Liab.Malpractice			167,081	167,081		167,081	46,445	213,526								26
27	Other (specify):*																27
28	TOTAL General Administration	382,022	18,075	1,796,816	2,196,913		2,196,913	(110,749)	2,086,164								28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,611,602	509,255	2,517,964	7,638,821		7,638,821	(67,854)	7,570,967								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 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	
	D. Ownership											
30	Depreciation			14,615	14,615		14,615	170,675	185,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							114,448	114,448			32
33	Real Estate Taxes							156,930	156,930			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			19,530	19,530		19,530		19,530			35
36	Other (specify):* Mortgage Insurance							14,746	14,746			36
37	TOTAL Ownership			490,145	490,145		490,145	799	490,944			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,171	328,863	496,034		496,034		496,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			684,029	684,029		684,029		684,029			42
43	Other (specify):* Non-Allowable Cos	90,370		138,093	228,463		228,463	(228,463)				43
44	TOTAL Special Cost Centers	90,370	167,171	1,150,985	1,408,526		1,408,526	(228,463)	1,180,063			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,701,972	676,426	4,159,094	9,537,492		9,537,492	(295,518)	9,241,974			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	(11,148)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	40,256	30		9
10	Interest and Other Investment Income	(4,405)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		43		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	(3,704)	43		18
19	Entertainment				19
20	Contributions		43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(121,188)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(108,407)	43		24
25	Fund Raising, Advertising and Promotional	(2,781)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(141,004)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (352,381)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	56,863		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 56,863		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (295,518)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (13,050)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Reclass to repairs and maintenance	4,038	6	3
4	Lab Expense Med A	(3,268)	43	4
5	X Ray Expense Med A	(3,505)	43	5
6	Managed Care Cost	(1,141)	43	6
7	Travel & Entertainment	(1,429)	43	7
8	Damage Loss	(2,710)	43	8
9	Disallow Management fees	(27,500)	17	9
10	Offset miscellaneous income	(2,069)	21	10
11	Payroll -Administrative Marketing Expense	(90,370)	43	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	(141,004)		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 Ownership		See PG6-Supp		See PG6-Supp		

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	\$	Cahokia Building LLC	100.00%	\$ 45,468	\$ 45,468	1
2	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	46,445	46,445	2
3	V	30	Depreciation		Cahokia Building LLC	100.00%	130,419	130,419	3
4	V	32	Interest Income	32	Cahokia Building LLC	100.00%		(32)	4
5	V	32	Interest		Cahokia Building LLC	100.00%	117,397	117,397	5
6	V	33	Real Estate Tax		Cahokia Building LLC	100.00%	156,930	156,930	6
7	V	34	Rent	456,000	Cahokia Building LLC	100.00%		(456,000)	7
8	V	36	Mortgage Insurance		Cahokia Building LLC	100.00%	14,746	14,746	8
9	V	21	Misc Expense		Cahokia Building LLC	100.00%	2	2	9
10	V	30	Amortization		Cahokia Building LLC	100.00%	1,488	1,488	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 456,032			\$ 512,895	\$ * 56,863	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		N/A	\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	0 39

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

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			Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Supportive		Supportive Living	1
2			Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3								3
4								4
5			Franklin Grove Living & Rehabilitation, LLC	Franklin Grove				5
6			Oregon Living & Rehabilitation, LLC	Oregon	Oregon Property LLC		Real Estate	6
7			Prairie Crossing Living & Rehab Center	Shabbona	Prairie Crossing		Real Estate	7
8					Property LLC			8
9								9
10			Tower Hill Rehabilitation LLC	South Elgin	Tower Hill Property LLC		Real Estate	10
11								11
12					FOM Property LLC		Real Estate	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

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	Elly Bachrach		Administrative	23.67	92,500	20	50.00	Guar Pmt	\$ 92,500	17(3,7)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Autumn Meadows of Cahokia # 0039636 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		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										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	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 2,907,118	12/1/2036	6.35%	\$ 117,397	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Sheldon	X		Shareholder loan			200,000	200,000				6	
7												7	
8												8	
9	TOTAL Facility Related				\$23,524.00		\$ 4,161,000	\$ 3,107,118			\$ 117,397	9	
	B. Non-Facility Related*												
10												10	
11								Amortization			1,488	11	
12								Interest Income Offset			(4,437)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,949)	14	
15	TOTALS (line 9+line14)						\$ 4,161,000	\$ 3,107,118			\$ 114,448	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 14,746 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	124,798	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024	\$	138,128	2
3. Under or (over) accrual (line 2 minus line 1).			\$	13,330	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	143,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			\$		
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	156,930	7
Assessed Value from Real Estate Tax Bill: 2024 726,143 8					
Real Estate Tax Bill for Calendar Year: 2020 126,798 9					
2021 114,648 10					
2022 111,825 11					
2023 124,716 12					
2024 138,128 13					
2024 RE Tax Accrual = \$138,128 X 1.04% = \$143,655.10 use \$143,600					
		FOR BHF USE ONLY			
		14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
		15	PLUS APPEAL COST FROM LINE 5	\$	15
		16	LESS REFUND FROM LINE 6	\$	16
		17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Autumn Meadows of Cahokia COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 06-02.0-310-055	Long Term Care Property	\$ 130,156.74	\$ 130,156.74
2. 06-02.0-310-054	Long Term Care Property	\$ 2,823.86	\$ 2,823.86
3. 06-02.0-310-040	Long Term Care Property	\$ 5,147.80	\$ 5,147.80
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 138,128.40	\$ 138,128.40

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932B. General Construction Type: Exterior BrickFrame WoodNumber of Stories One

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. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N
G. Have you properly capitalized all major repairs and equipment purchases? Y
H. Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? N
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:

1. Total Amount Incurred: N/A2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care			\$230,000	1
2	Office Space for Resident Care Employees			15,000	2
3	TOTALS			\$245,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		2001		\$ 2,928,441	\$	15-40	\$ 68,691	\$ 68,691	\$ 1,746,613	4
5			2006		55,820	2,030	40	1,395	(635)	27,693	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		17,859		20			17,859	9
10	Various		1995		33,623		20			33,623	10
11	Various		1996		2,178		20			2,178	11
12	Various		1997		9,423		20			9,423	12
13	Various		1998		4,800		20			4,800	13
14	Various		1999		16,266		20			16,266	14
15	Air Handler		2000		1,516		5			1,516	15
16	Alarm System		2001		1,908		5			1,908	16
17	Blind		2001		1,212		5			1,212	17
18	Air Handler		2001		1,317		20			1,317	18
19	Fan Motor		2001		1,123		20			1,123	19
20	Drywall-Dining Room		2002		10,650		10			10,650	20
21	Door		2002		9,860		20			9,860	21
22	Air Conditioner		2002		1,198		7			1,198	22
23	Air Conditioner		2002		1,582		7			1,582	23
24	Air Conditioners		2002		4,284		7			4,284	24
25	Compressor Air Maxi		2002		1,269		7			1,269	25
26	Roof - New		2003		97,996		20			97,996	26
27	Nursing Station		2003		35,060		20			35,060	27
28	Nursing Station		2003		28,692		20			28,692	28
29	Nursing Station		2003		6,368		20			6,368	29
30	Replace Accelerator		2003		968		20			968	30
31	Sprinkler System		2004		3,610		20			3,610	31
32	Smoke shelter		2004		6,041		20			6,041	32
33	Security System		2005		11,166		20	284	284	11,166	33
34	Condensing Unit - 5 Ton		2005		1,959		20	48	48	1,959	34
35	Cabinets and countertops		2005		110,923		20	2,775	2,775	110,923	35
36	Air Handler		2005		1,549		20	31	31	1,549	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

Facility Name & ID Number Autumn Meadows of Cahokia

0039636

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Asphalt Parking Lot	2005	\$ 5,570	\$	20	\$ 138	\$ 138	\$ 5,570	37
38	A/C Unit 2 Tons	2005	1,092		20	27	27	1,092	38
39	Reframe & drywall 3 windows	2005	4,200		20	105	105	4,200	39
40	Carpet & Vinyl Floor	2005	4,390		20	109	109	4,390	40
41	Sprinkler System - new pipe	2005	1,463		20	37	37	1,463	41
42	Door Alarms	2005	3,587		20	91	91	3,587	42
43	Wallpaper	2005	17,835		20	445	445	17,835	43
44	Painting and Wallcovering	2005	29,600		20	740	740	29,600	44
45	6 Doors	2005	1,926		20	49	49	1,926	45
46	Plaster Ceiling	2005	10,392		20	259	259	10,392	46
47	Vinyl Flooring	2005	4,878		20	122	122	4,878	47
48	Duct Heater	2006	1,195		20	60	60	1,166	48
49	Kitchen Garbage Disposal	2006	1,467		20	73	73	1,429	49
50	Copper Pipe & Concrete	2006	3,722		20	186	186	3,628	50
51	Fence	2006	6,061	358	20	303	(55)	5,909	51
52	Shower Remodel - Hall 400	2006	21,570	785	20	1,079	294	21,032	52
53	Tile Kitchen Floor	2006	9,750	355	20	488	133	9,508	53
54	Shower Remodel - Hall 200	2006	21,570	785	20	1,079	294	21,032	54
55	Shower Remodel - Hall 500	2006	21,570	785	20	1,079	294	21,032	55
56	Sprinkler System - new pipe	2006	19,579	712	20	979	267	19,090	56
57	Front Entrance	2006	2,150	78	20	108	30	2,098	57
58	4 ton & 1 1/2 Ton condensing Units	2006	3,361	122	20	168	46	3,276	58
59	3 Ton Condensing Unit	2006	1,729	63	20	86	23	1,685	59
60	Compressor-Walk In Freezer	2006	1,784		20	89	89	1,739	60
61	Air Conditioners (5)	2006	2,146		10			2,146	61
62	Air Conditioners (6)	2006	2,576		20	129	129	2,512	62
63	Phone System	2006	1,658		20	83	83	1,617	63
64	Remove & reinstall 6 dry pendants	2007	3,039	111	20	152	41	2,812	64
65	2 Hot Water Heaters	2007	7,500	273	20	375	102	6,938	65
66	2 Mixing valves for hot water heaters	2007	3,160	115	20	158	43	2,402	66
67	New Window Glass	2007	3,562		20	178	178	3,294	67
68	Paving, Parking Lot & Driveway	2007	32,275	1,773	20	1,614	(159)	23,850	68
69	Handrails	2007	2,980		20	149	149	2,757	69
70	TOTAL (lines 4 thru 69)		\$ 3,667,998	\$ 8,345		\$ 83,959	\$ 75,614	\$ 2,444,588	70

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

Facility Name & ID Number Autumn Meadows of Cahokia

0039636

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,667,998	\$ 8,345		\$ 83,959	\$ 75,614	\$ 2,444,588	1
2	Fire Damper and Roof Vent	2007	5,114	103	20	256	153	4,731	2
3	Dining Room Flooring-Ceramic, not glued down	2007	8,790		20	440	440	8,132	3
4	Walk In Freezer Door	2008	2,316	84	20	116	32	2,142	4
5	Replace 4 Inch Main	2008	3,158	115	20	158	43	2,764	5
6	Sprinkler heads for alarm	2008	29,310	1,066	20	1,466	400	25,648	6
7	Sign	2009	2,685		20	134	134	2,349	7
8	Hot Water Heater	2009	5,182	185	20	259	74	4,274	8
9	Vinyl Flooring	2009	14,512		20	726	726	11,979	9
10	Hot Water Heater	2010	5,094		20	255	255	4,207	10
11	Valves	2011	3,310	120	20	166	46	2,566	11
12	100 gallon hot water heater	2011	33,231	1,208	20	1,662	454	24,094	12
13	Security system - Phase 1 & 2	2011	21,394		20	1,070	1,070	15,511	13
14									14
15	Patio	2012	5,847		20	292	292	5,165	15
16	Gazebo	2012	19,098		20	955	955	10,504	16
17									17
18	Duct Heater	2013	3,213		20	161	161	2,008	18
19	Two Water Heaters & replace 2" main shut off valve &	2013	15,085		20	754	754	9,428	19
20	1 1/2" swing check valve								20
21									21
22	A/C Units	2013	4,380		20	219	219	2,738	22
23	-Removal of existing outdoor A/C unit								23
24	-Install a new 1 1/2 ton A/C unit and a 4 ton A/C unit								24
25	-Install A new trunk line and insulate with duct liner								25
26	-Install A new liquid line filter drier & pressure test								26
27									27
28	Parking Lot Improvement	2013	54,724		20	2,736	2,736	34,203	28
29	-Update the parking lot by milling butt joints,								29
30	patching failed areas, cleaning, applying a primer coat								30
31	-Installed 1.5' Hot Mix Asphalt Overlay								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,904,441	\$ 11,226		\$ 95,782	\$ 84,556	\$ 2,617,029	34

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

Facility Name & ID Number Autumn Meadows of Cahokia

0039636

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,904,441	\$ 11,226		\$ 95,782	\$ 84,556	\$ 2,617,029	1
2	Basement Remodel	2013	30,088		20	1,504	1,504	18,805	2
3	-Frame walls and exterior concrete								3
4	-Replace electrical can lights and recepticals								4
5	-Add heat register in office								5
6	-Install commercial carpet on floor								6
7	-Replace drywall walls and ceilings								7
8	-Replace 4 windows								8
9	-Add sink and new plumbing								9
10	-Crack in wall repair								10
11									11
12	Fire alarm replacement	2013	17,758		20	888	888	11,099	12
13									13
14	Asphalt and sealcoating - Driveway and 2 Walkways	2014	2,750	85	20	138	53	1,787	14
15	Remove and replace patio	2014	17,831		20	892	892	10,698	15
16	New exhaust fan and installation on roof	2014	3,210	117	20	161	44	1,926	16
17	Replace transfer switches - Generator	2014	4,727	172	20	236	64	2,836	17
18	3 ton air handler & 5 ton air handler & ductwork-Mech Room	2014	3,100		20	155	155	1,860	18
19	Replace new PVC drain, toilet, sink, sump pump-Office	2014	2,647	96	20	132	36	1,588	19
20									20
21	Replace original ductwork - Several areas of facility	2015	7,029		20	351	351	3,691	21
22	Remove concrete floor to replace damaged pipes with PVC	2015	3,000		20	150	150	1,575	22
23	Replace heat packages in offices, nurses stations, D Hall 400 & 600	2015	3,074		20	154	154	1,614	23
24	Wanderguard transmitter	2015	2,686		20	134	134	1,410	24
25	5 PTAC heaters	2015	2,869		20	143	143	1,507	25
26									26
27	Asphalt sidewalk - Behind Bldg & South Side	2016	12,882	551	20	644	93	6,763	27
28	Replaced 4" main - 100 Hall	2016	4,689	171	20	234	63	2,227	28
29	Hot water heater - 400 Hall in rear mechanical room	2016	7,775	283	20	389	106	3,693	29
30	Dry pendant head - 500 Hall	2016	9,190	334	20	460	126	4,365	30
31	Freezer condenser unit - Kitchen Walk-In freezer	2016	4,154	151	20	208	57	1,973	31
32	AC unit - Electrical Room	2016	5,476	199	20	274	75	2,601	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,049,376	\$ 13,385		\$ 103,029	\$ 89,644	\$ 2,699,048	34

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

Facility Name & ID Number Autumn Meadows of Cahokia

0039636

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,049,376	\$ 13,385		\$ 103,029	\$ 89,644	\$ 2,699,048	1
2	Hot water heater - 100 Hall by nrs stn & frt mech rm (3 total)	2016	7,307	266	20	365	99	3,471	2
3	Replaced AC unit compressors - Library unit	2016	3,862	140	20	193	53	1,834	3
4	Hot water heater - 100 Hall by nrs stn & frt mech rm (3 total)	2016	6,000	218	20	300	82	2,850	4
5	10 PTAC Units - throughout building	2016	5,578	321	5		(321)	5,578	5
6	6 PTAC Units - throughout building	2016	3,819	220	5		(220)	3,819	6
7	Replaced ducts, pipes & heat packages - throughout building	2016	13,104		15	874	874	8,209	7
8									8
9	Replace fire sprinklers-Entire building	2017	257,398		40	6,434	6,434	54,689	9
10	Custom monument sign & refurbish cabinet	2017	11,514	1,090	10	1,151	61	9,586	10
11	Install subpanel & remove A/C out of generator panel, fix	2017	2,557		20	128	128	1,088	11
12	electrical code repairs - Mechanical Room								12
13	Sprinkler project submission fee - Entire building	2017	2,923	106	5		(106)	2,923	13
14	Compressor and filter drier - Mechanical Room	2017	2,723	99	10	272	173	2,335	14
15	6 PTAC Units - throughout building	2018	3,997		5			3,997	15
16									16
17	Install sprinkler box - caulk, mud & tape between walls - entire bu	2019	3,500	5	10	350	345	2,129	17
18	Install New Sprinkler System - Entire Building	2019	75,000	2,613	20	3,750	1,137	26,250	18
19	RE 3 ton low ambient condenser with 4 HD wall units- D Wing	2019	10,495		15	700	700	4,547	19
20	RE Install new 2 ton a/c unit and airhandler- Laundry Area	2019	3,983		15	266	266	1,726	20
21	RE Install Boiler tank water heater and connect water lines- Mech	2019	11,000		15	733	733	4,767	21
22	RE New Roof and wood replacement- Entire building	2019	10,000		15	667	667	4,333	22
23									23
24	Install Water Heater For Kitchen And Laundry	2020	12,209		15	814	814	4,477	24
25	and Install Thermo Expansion Tank To Water Heater								25
26	Install Fire alarm system - Throughout Facility	2020	34,987		15	2,332	2,332	12,828	26
27	Rebuild generator - Mechanical Room	2020	6,507		15	434	434	2,386	27
28	Lightning protection system - Exterior of Facility	2020	17,623		15	1,175	1,175	6,462	28
29	6 PTAC units - throughout building	2020	3,418		5	342	342	3,418	29
30	Replace Condensing unit - Front Office	2020	3,650		5	365	365	3,650	30
31	Coil on above condensing unit - Front Office	2020	2,862		5	286	286	2,862	31
32	Replace compressor in RUDD unit - Mechanical Room	2020	2,688		5	269	269	2,688	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,568,080	\$ 18,463		\$ 125,228	\$ 106,765	\$ 2,881,951	34

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,568,080	\$ 18,463		\$ 125,228	\$ 106,765	\$ 2,881,951	1
2									2
3	Water heater	2021	22,242		15	1,483	1,483	6,672	3
4	Replace condensor, htg element & blower motor - HVAC 500 Hall	2021	7,261		5	1,452	1,452	6,535	4
5									5
6									6
7	Broke bottom of laundry pit. Broke floor under washing machine	2023	20,307	1,218	15	1,354	136	3,925	7
8	Replaced ten feet of waste with new trap and floor drain in bottom								8
9	of laundry pit								9
10									10
11									11
12	Installed air handler with 15kw electric heat and 4 ton condensor	2024	7,901	527	15	527		803	12
13	Installed one water heater and expansion tank	2024	13,452	897	15	897		1,507	13
14	Installed one water heater, expansion tank and 2 mixing valves	2024	13,452	897	15	897		1,507	14
15	Evaporator coils	2024	5,810	387	15	387		494	15
16	5 ton 32 a/c and air handler	2025	10,276	239	15	239		239	16
17	Repair 12 shower bases	2025	41,265	897	15	897		897	17
18	Install new sprinklers	2025	6,198	79	15	79		79	18
19	4 ton air handler in attic	2025	9,706	220	15	220		220	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Tie to current book depreciation								29
30				(21,082)			21,082		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,725,950	\$ 2,742		\$ 133,659	\$ 130,918	\$ 2,904,829	34

**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	\$39,968	\$8,833	\$8,833	\$	5-10	\$26,458	71
72	Current Year Purchases	43,506	3,040	3,040		7	3,040	72
73	Fully Depreciated Assets	540,315					540,315	73
74	Real Estate Entity	1,164,287		39,758	39,758		1,145,537	74
75	TOTALS	\$1,788,076	\$11,873	\$51,631	\$39,758		\$1,715,350	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	Facility Use	2014 Chrysler Town & Country	2014	\$32,407	\$	\$	\$	10	\$32,407	76
77										77
78										78
79										79
80	TOTALS			\$32,407	\$	\$	\$		\$32,407	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)	\$6,791,433	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$14,615	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$185,290	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$170,676	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,652,586	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:	N/A			\$			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?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$19,530
- Description: See attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	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 Ending	Annual 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.

Facility Name:

Autumn Meadows of Cahokia

IDPH License ID Number:

0039636

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental-Medicaid	13,919
Nursing Equipment Rental-Clinical - Nursing	(1,029)
Office Equipment Rental-Administrative	5,093
Medical Equipment Rental-Medicare A	1,354
Medical Equipment Rental-Private	-
Building & Facility Equipment Rental-Environmental	-
Medical Equipment Rental-Private	193
Total - Line 16	19,530

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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	39(3)	hrs	\$		1,986	\$ 142,963	\$	1,986	\$ 142,963	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			306	22,025		306	22,025	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39(3)	hrs			2,276	163,875		2,276	163,875	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescripts					141,811		141,811	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): IV Therapy	39(2)						25,360		25,360	12
13	Other (specify):										13
14	TOTAL			\$		4,568	\$ 328,863	\$ 167,171	4,568	\$ 496,034	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 128,605	\$ 157,379	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (84,940))	1,428,395	1,428,395	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,517	49,262	6
7	Other Prepaid Expenses	60,012	60,012	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	70,652	591,045	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,714,181	\$ 2,286,093	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000	245,000	13
14	Buildings, at Historical Cost	55,818	2,984,261	14
15	Leasehold Improvements, at Historical Cost	876,718	1,741,689	15
16	Equipment, at Historical Cost	548,970	1,820,483	16
17	Accumulated Depreciation (book methods)	(1,015,384)	(4,652,586)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec)Capitalized Costs		29,003	22
23	Other(specify): See Schedule 17A	104,154	224,154	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 585,276	\$ 2,392,004	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,299,457	\$ 4,678,097	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (4,349)	\$ 3,431	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,413	238,413	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,605	19,605	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,600	32
33	Accrued Interest Payable		9,642	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,704,640	1,967,452	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,958,309	\$ 2,382,143	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,000	200,000	39
40	Mortgage Payable		2,907,118	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)	\$ 200,000	\$ 3,107,118	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,158,309	\$ 5,489,261	46
47	TOTAL EQUITY(page 18, line 24)	\$ 141,148	\$ (811,164)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,299,457	\$ 4,678,097	48

*(See instructions.)

Facility Name:Autumn Meadows of Cahokia

IDPH License ID Number:0039636

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Current Assets (specify):

	Description	Operating	Consolidation
1130	RE ESCROW - INSURANCE	-	16,200
1131	RE ESCROW - MIP	-	33,114
1132	RE ESCROW - REPL RESERVE	-	256,728
1133	RE ESCROW - REAL ESTATE TAX	-	214,351
101800	Miscellaneous Receivables	70,652	70,652
Total - Line 9		70,652	591,045
		-	-

Line 23 Long Term Assets (specify):

	Description	Operating	Consolidation
2211	RE Due t/f Cahokia Nursing	-	120,000
114700	Clearing Account	-	-
125110	Due To/From - Cahokia Vacant Property	10,827	10,827
129300	Due To/From - Members/RelatedParty	93,327	93,327
		-	-
Total - Line 23		104,154	224,154
		-	-

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
1955	RE ACCUM AMORTIZATION	-	7,516
2190	RE DUE TO CAHOKIA NURSING	-	255,296
125108	Due To/From - Caseyville Nursing & Rehab Center	747,631	747,631
128002	Due To/From - Maestro	-	-
129301	Due To/From - Associated Propco	(135,297)	(135,297)
129303	Due To/From - SW Financial	78,535	78,535
200010	Accounts Payable - Trade	627,310	627,310
200100	Accrued Payables	25,710	25,710
200101	Accrued Payables - Professional Fees	(27,114)	(27,114)
200120	Accrued Payables - Health Insurance	21,017	21,017
200121	Accrued Payable - Dental Insurance	1,132	1,132
200124	Accrued Payables - Short Term Disability	1,864	1,864
200290	Accrued Payables - 401K Deductions	(4,361)	(4,361)
200350	Fringe Benefits - Flow Through	7,891	7,891
200400	Accrued Payables - Business Insurance	106,248	106,248
200510	Accrued Payables - Bed Taxes Add'l	219,073	219,073
200600	Accrued Payables - Management Fees	35,000	35,000
Total - Line 36		1,704,640	1,967,452
		-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 695,578	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 695,576	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(554,428)	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)	\$ (554,428)	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)	\$ 141,148	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Autumn Meadows of Cahokia

0039636

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	\$ 8,665,977	1
2	Discounts and Allowances for all Levels	(456,083)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,209,894	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	646,162	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 646,162	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	61,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,318	19
20	Radiology and X-Ray	275	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,405	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,405	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See SCH 19A	58,116	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58,116	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,983,064	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,487,269	31
32	Health Care	3,954,639	32
33	General Administration	2,196,913	33
	B. Capital Expense		
34	Ownership	490,145	34
	C. Ancillary Expense		
35	Special Cost Centers	724,497	35
36	Provider Participation Fee	684,029	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,537,492	40
41	Income before Income Taxes (line 30 minus line 40)**	(554,428)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (554,428)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,352,295	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,402,375	45
46	MMAI-Medicaid is the Primary Payer	123,911	46
47	MMAI-Medicare is the Primary Payer	-11,469	47
48	Private Pay	22,370	48
49	Medicare Part A	471,213	49
50	Other-(specify) Hospice	506,959	50
51	Other-(specify) VA	1,575,457	51
52	Other-(specify) Medicare Part B	-233,217	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)	\$ 8,209,894	56

Facility Name: Autumn Meadows of Cahokia
IDPH License ID Number: 0039636
Fiscal Year End: 12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Other Income - Other	(2,069)
Quality Incentive Program-Other	(56,300)
Sequestration Expense-Managed Care	253
	-
	-
	-
Total - Line 28	(58,116)
	-

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	1,904	2,263	\$ 131,269	\$ 58.01	1
2	Assistant Director of Nursing	1,208	1,256	78,208	62.27	2
3	Registered Nurses	7,912	8,877	420,770	47.40	3
4	Licensed Practical Nurses	16,215	17,837	774,339	43.41	4
5	CNAs & Orderlies	70,509	76,823	1,675,586	21.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,978	4,370	75,611	17.30	10
11	Social Service Workers	2,619	2,933	63,404	21.62	11
12	Dietician					12
13	Food Service Supervisor	1,666	1,794	49,368	27.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,084	5,496	99,010	18.01	15
16	Dishwashers	9,353	9,837	156,194	15.88	16
17	Maintenance Workers	5,009	5,673	124,602	21.96	17
18	Housekeepers	12,339	13,596	213,531	15.71	18
19	Laundry	6,748	7,336	132,796	18.10	19
20	Administrator	1,832	2,122	127,413	60.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,812	4,076	110,012	26.99	23
24	Clerical	13,788	15,475	365,998	23.65	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	1,898	2,092	38,197	18.26	31
32	Other Health Care: Admissions Cord.	1,928	2,080	65,665	31.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	167,802	183,936	\$ 4,701,972 *	\$ 25.56	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	\$ 9,691	L1, C3	35
36	Medical Director	Monthly	27,832	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,425	L10, C3	38
39	Pharmacist Consultant	Monthly	13,247	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,195		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,066	\$ 63,378	L10, C3	50
51	Licensed Practical Nurses	4,273	234,943	L10, C3	51
52	Certified Nurse Assistants/Aides			L10, C3	52
53	TOTAL (lines 50 - 52)	5,339	\$ 298,321		53

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

** See instructions.

3,118,367

Facility Name: Autumn Meadows of Cahokia
IDPH License ID Number: 0039636
Fiscal Year End: 12/31/2025

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Approved Admissions, LLC	Admission Process Consulting	1,800
AT&T	Internet	168
Dell Technologies	Computer service	890
Direct Supply Inc.	Supplies	1,197
Inovalon Provider, Inc.	Medicare Claim Management	6,447
ITSavvy LLC	IT services	332
John Grawitch	Travel & expense	28
Mobilex USA	Mobile service	420
RADAR Apps LLC	Cloud based software and services	1,996
Spectrum	Internet	3,052
Trendnet	Internet	332
WellSky Corporation	Data Analytics	6,696
RSM	Accounting	12,000
Legal accrual	Legal	24,000
Mosier Reporting Services LLC	Legal	1,334
National Healthcare Innovations	Legal	3,880
Rynearson, Suess, Schnurbusch & Champic	Legal	304
Ashman & Stein, P.C.	Legal	152,598
PointClickCare Technologies Inc.	Cloud Based Software And Services	38,857
Law Offices of Michael Z. Margolies	Legal	600
McCorkle Litigation Services,Inc	Legal	2,649
Gregg Davis MD MBA Ltd	Legal	6,665
SJ Consultants LLP	Legal	14,375
Centers for Medicare & Medicaid	Legal	35,925
INSPE Associates LLC	Legal	1,365
AssuredPartners Cornerstone LL	Insurance	144
Bock and Clark Corporation	Surveyors	1,625
Bureau Veritas Technical Assessment	Testing and inspection	2,550
Certisurv LLC	Staffing agency	950
Hillel Bachrach	Medical Consult	805
Paylocity	Payroll service	846
Symphony Fees	Management	465,701
Total (agree to Schedule V, line 19, column 3)		790,531
Allocated from Management Company Legal Fees		
Allocated from Management Company Professional Services		45,468
Less: Non-Allowable Legal Fees		(121,188)
Reclass Point Click Care		(38,857)
Total (agree to Schedule V, line 19, column 8)		675,954

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
HEALTH CARE COUNCIL OF IL (HCCI)	13,050
	13,050 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)	13,050
	13,050 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	26,100
	26,100 Total
- (5)

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

\$ 23,254 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.

\$ 684,029

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?

No 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?

N/A

d. Have vehicle usage logs been maintained?

Adequate records have been maintained

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

No

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

Yes

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

No
- (13)

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

Firm Name: N/A

No
- (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.