

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0042226

Facility Name: Brookdale Plaza Lisle SNF

Address: 1800 Robin Lane Lisle 60532
Number City Zip Code

County: DuPage

Telephone Number: (630) 810-0500 Fax # (630) 810-0600

HFS ID Number:

Date of Initial License for Current Owners: 12/13/2000

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name)
(Title)

Paid
Preparer

(Signed)
(Print Name and Title) Andrew B. Cutler
Managing Director
(Firm Name & Address) FGMK, LLC
2801 Lakeside Drive, 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 964-5469

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

Brookdale Plaza Lisle SNF

0042226

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	27	Sheltered Care (SC)	27	9,855	5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	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	
8	SNF		3,584			9,461	2,495	1,859	17,399	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC					4,477			4,477	12
13	DD 16 OR LESS									13
14	TOTALS		3,584			13,938	2,495	1,859	21,876	14

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

73.09%

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 ☒

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 01/01/2001

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

YES ☒ Date 03/02/2009 NO ☐

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

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 55

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

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

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

Facility Name & ID Number

Brookdale Plaza Lisle SNF

0042226

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	425,787	25,830	6,987	458,604		458,604		458,604			1
2	Food Purchase		382,672		382,672		382,672		382,672			2
3	Housekeeping	190,831	38,461	5,225	234,517		234,517		234,517			3
4	Laundry	63,837			63,837		63,837		63,837			4
5	Heat and Other Utilities			122,665	122,665		122,665		122,665			5
6	Maintenance		51,344	271,692	323,036		323,036		323,036			6
7	Other (specify):*											7
8	TOTAL General Services	680,455	498,307	406,569	1,585,331		1,585,331		1,585,331			8
	B. Health Care and Programs											
9	Medical Director			33,750	33,750		33,750		33,750			9
10	Nursing and Medical Records	3,385,467	129,784	272,138	3,787,389		3,787,389		3,787,389			10
10a	Therapy											10a
11	Activities	125,406	23,689		149,095		149,095		149,095			11
12	Social Services	70,410	2,451	561	73,422		73,422		73,422			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,581,283	155,924	306,449	4,043,656		4,043,656		4,043,656			16
	C. General Administration											
17	Administrative	164,531		5,666	170,197		170,197		170,197			17
18	Directors Fees											18
19	Professional Services			23,863	23,863		23,863	(66)	23,797			19
20	Dues, Fees, Subscriptions & Promotions			135,625	135,625		135,625	(27,670)	107,955			20
21	Clerical & General Office Expenses	931,814	28,471	212,556	1,172,841		1,172,841	(162,079)	1,010,762			21
22	Employee Benefits & Payroll Taxes			941,176	941,176		941,176		941,176			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,123	5,123		5,123		5,123			24
25	Other Admin. Staff Transportation			3,104	3,104		3,104		3,104			25
26	Insurance-Prop.Liab.Malpractice			184,778	184,778		184,778		184,778			26
27	Other (specify):*											27
28	TOTAL General Administration	1,096,345	28,471	1,511,891	2,636,707		2,636,707	(189,815)	2,446,892			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,358,083	682,702	2,224,909	8,265,694		8,265,694	(189,815)	8,075,879			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			358,401	358,401		358,401		358,401			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			140,233	140,233		140,233		140,233			33
34	Rent-Facility & Grounds			4,533	4,533		4,533		4,533			34
35	Rent-Equipment & Vehicles			508	508		508		508			35
36	Other (specify):*											36
37	TOTAL Ownership			503,675	503,675		503,675		503,675			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,990	535,046	724,036		724,036		724,036			39
40	Barber and Beauty Shops		21,388		21,388		21,388	(21,388)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			139,757	139,757		139,757		139,757			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		210,378	674,803	885,181		885,181	(21,388)	863,793			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,358,083	893,080	3,403,387	9,654,550		9,654,550	(211,203)	9,443,347			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(2,006)	21		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	(18,551)	21		24
25	Fund Raising, Advertising and Promotional	(25,764)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(164,882)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (211,203)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (211,203)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (1,906)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable P/Y Tax Adjustments	21,193	21	3
4	Non-Allowable Other non-Operating Expense	(9)	21	4
5	Non-Allowable Marketing Salaries	(144,074)	21	5
6	Non-Allowable Legal Collection Fees	(66)	19	6
7	Barber and Beauty Income Offset	(21,388)	40	7
8	Non-Allowable Paid Referrals	(18,632)	21	8
9				9
10				10
11				11
12				12
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(164,882)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Brookdale Living Communities, Inc.	100%					
Wholly owned subsidiary of						
Brookdale Senior Living Inc.						
(Publicly Traded Company)						

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								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			\$			\$	\$ *	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			\$			\$	\$	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	\$ *	39

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

STATE OF ILLINOIS						Ownership Listing-1		
Brookdale Plaza Lisle SNF								
ID# 0042226								
Report Period Beginning: 1/1/2025								
Ending: 12/31/2025								
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)						Management		
-Owners of companies must be listed instead of company names.						Co./Home Office		
-Names of trust beneficiaries must be listed.						Operator/Licensee		
First Name		M.I.	Last Name	Place of Residence		Ownership Percentage	Building Co. Ownership Percentage	Ownership Percentage
City		State						
1	N/A - Public Traded Entity							1
2								2
3								3
4								4
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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 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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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	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

Facility Name & ID Number Brookdale Plaza Lisle SNF # 0042226 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	N/A												6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	N/A												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. \$ N/A Line # N/A

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

** 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	161,426	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.)				\$	140,233	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(21,193)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	161,426	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.				\$		6
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.				\$	140,233	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020		9			
	2021		10			
	2022	153,651	11			
	2023	148,116	12			
	2024	140,233	13			
2025 Accrual is the same as 2024 accrual for balancing only - facility lease was terminated at 12/31/2025.				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
No R/E tax accrual entry was posted.				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 Brookdale Plaza Lisle SNF COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0042226

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847)940-3269 FAX #: (847)964-5469

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-10-300-029	Long-Term Care Property	\$ 140,232.86	\$ 140,232.86
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 140,232.86	\$ 140,232.86

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.

A. Square Feet: 45,013

B. General Construction Type: Exterior Concrete Frame Cast In Place Rein. Co Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. List the bed capacity for the building if it differs from the licensed total.

N/A

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

Yes

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

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

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

YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2009		129,847					9
10	Various		2010		472,246					10
11	Various		2012		102,241					11
12	Various		2013		82,789					12
13	Various		2014		1,340,460					13
14	Various		2015		37,811					14
15	Various		2016		82,115					15
16	Various		2017		1,797,094					16
17	Various		2018		189,565					17
18	Various		2019		470,982					18
19	Pure Voltage/ Gazebo Electric		2020		813					19
20	Pure voltage/Lightpole Ballast		2020		1,400					20
21	Pure Voltage/ Steam Stable Electric		2020		813					21
22	ROCS Gazebo		2020		1,471					22
23	Interior renovations, walls, paint, Lighting, Electric		2020		165,610					23
24	Interior renovations, walls, paint, Lighting, Electric		2020		179,282					24
25	CIP Interest Interior Renovation - walls, paint, lighting, electric		2020		4,324					25
26	ROCS/Security Cage		2020		2,633					26
27	28991663 FC24 Ionization Units		2020		2,276					27
28	DIRECT/FC48 Ionization Units		2020		2,363					28
29	Grainter Thermostat Guards		2021		1,623					29
30	BU 00802 receiver Controller		2021		2,067					30
31	Electric For New Refridgerator - Dedicated 220 Electric		2023		2,800					31
32	Unit 207 Paint, Flooring, Lighting		2023		2,998					32
33	Pure Voltage Building Electrical		2023		39,135					33
34	Unit 201 Fire Guard Door		2024		4,697					34
35	2 Mini Split A/C Units		2024		18,600					35
36	Current Depreciation					358,401		358,401		5,999,166

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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	Chilled Water Pump	2024	\$ 7,628	\$		\$	\$	\$	37
38	Unit 235 Skilled Paint, Flooring Lighting	2024	5,535						38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,151,218	\$ 358,401		\$ 358,401	\$	\$ 5,999,166	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 370,174	\$	\$	\$		\$	71
72	Current Year Purchases	8,661						72
73	Fully Depreciated Assets	466,945						73
74								74
75	TOTALS	\$ 845,780	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,996,998	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 358,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 358,401	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)	\$ 5,999,166	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93		6,258,249	93
94			94
95		\$ 6,258,249	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: Ventas Realty Limited Partnership
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:	1987	82	7/26/2020	\$ 4,533			3
4	Additions							4
5								5
6								6
7	TOTAL		82		\$ 4,533			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: \$ 508 Description: Copy Machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	\$		\$ 42,182	\$		\$ 42,182	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			152,968			152,968	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			194,659			194,659	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				126,312		126,312	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					62,678		62,678	12
13	Other (specify): See Attached	39-3				145,237			145,237	13
14	TOTAL			\$		\$ 535,046	\$ 188,990		\$ 724,036	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.

Brookdale Plaza Lisle SNF
0042226
1/1/2025 - 12/31/2025

Page 16 SUPP

39-2	
Durable Medical Equipment	2,476.00
Oxygen	17,275.00
Wound Care Supplies	14,475.00
Ancillary Supplies	16,252.00
Radiology Services	<u>12,200.00</u>
Total	<u>62,678.00</u>

39-3	
Laboratory Services	45,277.00
Medical Equipment, Rental	98,850.00
Ambulance	<u>1,110.00</u>
Total	<u>145,237.00</u>

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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	690,646		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,393,004		8
9	Other(specify):	(136,246)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,947,404	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	5,151,218		15
16	Equipment, at Historical Cost	845,780		16
17	Accumulated Depreciation (book methods)	(5,999,166)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (2,168)	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,945,236	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,255	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,053		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,856		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses/Unearned Revenue	327,830		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 812,994	\$	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)	\$ 812,994	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,132,242	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,945,236	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,699,360	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,699,360	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,567,119)	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)	\$ (1,567,119)	17
	B. Transfers (Itemize):		
18			18
19	Rounding	1	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,132,242	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Brookdale Plaza Lisle SNF

0042226

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,363,930	1
2	Discounts and Allowances for all Levels	(1,487,081)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,876,849	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,370	6
7	Oxygen	370	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,740	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	21,474	13
14	Non-Patient Meals	38	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	102,223	18
19	Laboratory	45,109	19
20	Radiology and X-Ray	13,617	20
21	Other Medical Services	1,169,842	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,352,303	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	136	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 136	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	15,886	28
28a	Lease Termination Gain/Loss	(165,483)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (149,597)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,087,431	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,585,331	31
32	Health Care	4,043,656	32
33	General Administration	2,636,707	33
	B. Capital Expense		
34	Ownership	503,675	34
	C. Ancillary Expense		
35	Special Cost Centers	745,424	35
36	Provider Participation Fee	139,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,654,550	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,567,119)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,567,119)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	799,834.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,853,025.00	48
49	Medicare Part A	1,354,822.00	49
50	Other-(specify) Insurance	869,168.00	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)	\$ 6,876,849	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,240	3,240	\$ 164,152	\$ 50.66	1
2	Assistant Director of Nursing	828	828	34,568	41.75	2
3	Registered Nurses	44,403	44,403	1,335,866	30.09	3
4	Licensed Practical Nurses	21,432	21,432	511,383	23.86	4
5	CNAs & Orderlies	78,162	78,162	1,285,478	16.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,480	2,480	51,139	20.62	9
10	Activity Assistants	6,052	6,052	74,267	12.27	10
11	Social Service Workers	2,455	2,455	70,410	28.68	11
12	Dietician	2,473	2,473	64,226	25.97	12
13	Food Service Supervisor	2,480	2,480	66,273	26.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,790	20,790	295,287	14.20	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,560	12,560	190,831	15.19	18
19	Laundry	4,609	4,609	63,837	13.85	19
20	Administrator	2,480	2,480	164,531	66.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,252	9,252	931,814	100.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,321	2,321	54,021	23.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,017	216,017	\$ 5,358,083 *	\$ 24.80	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	\$ 6,987	1-3	35
36	Medical Director	Monthly	33,750	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	7	375	10-3	39
40	Physical Therapy Consultant	14	587	10-3	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)	21	\$ 41,699		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	294	\$ 18,540	10-3	50
51	Licensed Practical Nurses	388	24,417	10-3	51
52	Certified Nurse Assistants/Aides	995	62,690	10-3	52
53	TOTAL (lines 50 - 52)	1,677	\$ 105,647		53

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

** See instructions.

Brookdale Plaza Lisle SNF
0042226
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Seminar

Date	Line Description	Vendor Name	Amount	Type of Training
	1/4/2025 CPR Training	KIMBERLY SHUMPERT	390.00	Inservice training
	1/9/2025 AP Posting	PINEAPPLE ACADEMY INC	15.00	Inservice training
	2/4/2025 AP Posting	NATIONAL FIT TESTING SERVICES	360.00	Inservice training
	2/11/2025 AP Posting	PINEAPPLE ACADEMY INC	15.00	Inservice training
	3/3/2025 AP Posting	NATIONAL FIT TESTING SERVICES	375.00	Inservice training
	3/7/2025 AP Posting	PINEAPPLE ACADEMY INC	15.00	Inservice training
	3/14/2025 2091484PCFrank GuajardoLEADING	WELLS FARGO PROCUREMENT	99.00	Inservice training
	4/1/2025 AP Posting	MANAGED CARE GROUP LLC	650.00	Inservice training
	4/7/2025 AP Posting	NATIONAL FIT TESTING SERVICES	235.00	Inservice training
	5/6/2025 AP Posting	PINEAPPLE ACADEMY INC	15.05	Inservice training
	5/5/2025 2114662PCFrank GuajardoNIU OUT	WELLS FARGO PROCUREMENT	399.00	Inservice training
	6/1/2025 AP Posting	PINEAPPLE ACADEMY INC	15.04	Inservice training
	6/6/2025 AP Posting	PINEAPPLE ACADEMY INC	15.04	Inservice training
	9/1/2025 CPR Training \$65 (19 People)	KIMBERLY SHUMPERT	1,235.00	Inservice training
	9/29/2025 education for Life safety survey prep	LSC	99.00	Inservice training
	10/8/2025 wound certification class for staff member	Wound Care	85.00	Inservice training
	11/4/2025 Additional fit test hood	NATIONAL FIT TESTING SERVICES	25.00	Inservice training
	11/4/2025 Fit testing kit	NATIONAL FIT TESTING SERVICES	260.00	Inservice training
	11/4/2025 Shipping via UPS	NATIONAL FIT TESTING SERVICES	23.54	Inservice training
	11/11/2025 CPR Training	KIMBERLY SHUMPERT	650.00	Inservice training
	12/1/2025 ALLOCATION - PINEAPPLE ACADEMY JULY 2025 SUBSCRIPTIONS	PINEAPPLE ACADEMY INC	15.36	Inservice training
	12/1/2025 PINEAPPLE ACADEMY AUG 2025 SUBSCRIPTIONS	PINEAPPLE ACADEMY INC	15.36	Inservice training
	12/1/2025 PINEAPPLE ACADEMY SEPT 2025 SUBSCRIPTIONS	PINEAPPLE ACADEMY INC	15.36	Inservice training
	12/18/2025 PINEAPPLE ACADEMY OCT 2025 SUBSCRIPTIONS	PINEAPPLE ACADEMY INC	15.36	Inservice training
	12/9/2025 wound certification for ADCS	wound certification for ADCS	85.00	Inservice training
		Total	5,122.11	

Legal

Date	Line Description	Vendor Name	Amount
	4/1/2025 Legal	Forte Data Solutions	66.00
	5/14/2025 Legal	Smith Hemesch Burke	4,000.00
		Total	4,066.00

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
IL HEALTHCARE ASSOCIATION (IHCA)	4,154
	4,154
	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.

IL HEALTHCARE ASSOCIATION (IHCA)	1,906
	1,906
	Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	6,060
	6,060
	Total
- (5)

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

\$ 14,118

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.

\$ 139,757

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.

\$ 0

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

Np

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?

Ln 14

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?

N/A

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

N/A

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

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (13)

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

Firm Name: N/A

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.