

		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: 0019836

Facility Name: Buckingham Pavilion

Address: 2625 West Touhy Ave Chicago 60645
Number City Zip Code

County: Cook

Telephone Number: 773-973-5333 Fax # 773-973-5222

HFS ID Number:

Date of Initial License for Current Owners: 02/01/1975

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: Mendel S Schneider Telephone Number: 847-933-1274

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

(Signed) See Accountant's Report Attached

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address) Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076

(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

Buckingham Pavilion

#

0019836

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	247	Skilled (SNF)	247	90,155
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	247	TOTALS	247	90,155

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	6,136	17,723	1,188	139	9,044	3,397	1,657	39,284
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	6,136	17,723	1,188	139	9,044	3,397	1,657	39,284

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

43.57%

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

0

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

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

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

02/01/1975

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

YES

Date

NO

X

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

235

Medicare Intermediary

Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31

Fiscal Year:

12/31

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

Facility Name & ID Number Buckingham Pavilion # 0019836 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	365,949	43,846		409,795		409,795		409,795			1
2	Food Purchase		380,882		380,882		380,882	(6,138)	374,744			2
3	Housekeeping	307,667	45,599	24,161	377,427		377,427		377,427			3
4	Laundry	68,789			68,789		68,789		68,789			4
5	Heat and Other Utilities			250,109	250,109		250,109		250,109			5
6	Maintenance			133,850	133,850		133,850		133,850			6
7	Other (specify):*											7
8	TOTAL General Services	742,405	470,327	408,120	1,620,852		1,620,852	(6,138)	1,614,714			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,683,054	230,033	816,433	3,729,520		3,729,520		3,729,520			10
10a	Therapy											10a
11	Activities	51,189	18,365		69,554		69,554		69,554			11
12	Social Services	73,679			73,679		73,679		73,679			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,807,922	248,398	816,433	3,872,753		3,872,753		3,872,753			16
	C. General Administration											
17	Administrative	1,090,188			1,090,188		1,090,188		1,090,188			17
18	Directors Fees											18
19	Professional Services			51,748	51,748		51,748		51,748			19
20	Dues, Fees, Subscriptions & Promotions			297,998	297,998		297,998	(273,473)	24,525			20
21	Clerical & General Office Expenses	584,093	37,233	210,815	832,141		832,141	(95,722)	736,419			21
22	Employee Benefits & Payroll Taxes			493,601	493,601		493,601		493,601			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			384,231	384,231		384,231		384,231			26
27	Other (specify):* Bad Debt			75,000	75,000		75,000	(75,000)				27
28	TOTAL General Administration	1,674,281	37,233	1,513,393	3,224,907		3,224,907	(444,195)	2,780,712			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,224,608	755,958	2,737,946	8,718,512		8,718,512	(450,333)	8,268,179			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			142,430	142,430		142,430	(65,887)	76,543			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			483,040	483,040		483,040		483,040			33
34	Rent-Facility & Grounds			736,237	736,237		736,237	(736,237)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,361,707	1,361,707		1,361,707	(802,124)	559,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	142,206	147,904	258,736	548,846		548,846		548,846			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			634,456	634,456		634,456		634,456			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	142,206	147,904	893,192	1,183,302		1,183,302		1,183,302			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,366,814	903,862	4,992,845	11,263,521		11,263,521	(1,252,457)	10,011,064			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	(65,887)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,138)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,000)	27		24
25	Fund Raising, Advertising and Promotional	(273,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(95,722)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (516,220)		\$	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)	(736,237)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (736,237)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,252,457)		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	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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37				37
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 652,237	SRL Trust	100.00%	\$	\$ (652,237)	1
2	V	34	Rent	84,000	Waveland Joint Venture			(84,000)	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			\$ 736,237			\$	\$ *	(736,237) 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

Buckingham Pavilion

ID#0019836

Report Period Beginning:01/01/2025

Ending:12/31/2025

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

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

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1	Leah Kaslow Trust:							1
2	Beneficiary							2
3	Leah	S	Kazlow	Teaneck	NJ	30.00000	30.00000	3
4	Rita		Status	Savannah	GA	25.50000	25.50000	4
5								5
6	Rita Status Trust:							6
7	Beneficiary							7
8	Rita		Status	Savannah	GA	4.50000	4.50000	8
9	Sheldon		Stern	Chicago	IL	25.50000	25.50000	9
10								10
11	Sheldon Stern Trust:							11
12	Beneficiary							12
13	Sheldon		Stern	Chicago	IL	14.50000	14.50000	13
14								14
15								15
16								16
17								17
18								18
19								19
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73								73
74								74
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					SRL Trust	Chicago, Illinois	Bldg Rental	1
2					Waveland Joint Ventu	Chicago, Illinois	Bldg Rental	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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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	Sheldon Stern	Owner	Administrative	25.50		40	100.00	Salary	\$ 380,275	17-1	1
2	Eric Stern	Relative	Administrative	0.00		40	100.00	Salary	597,500	17-1	2
3	Steven Gross	Relative	Administrative	0.00		40	100.00	Salary	112,413	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,090,188		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 Buckingham Pavilion # 0019836 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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Buckingham Pavilion # 0019836 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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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

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

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

B. Real Estate Taxes

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 Buckingham Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019836

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-36-201-001-0000	Long Term Care	\$ 6,274.61	\$ 6,274.61
2. 10-36-201-002-0000	Long Term Care	\$ 5,639.89	\$ 5,639.89
3. 10-36-201-003-0000	Long Term Care	\$ 44,842.65	\$ 44,842.65
4. 10-36-201-004-0000	Long Term Care	\$ 106,927.58	\$ 106,927.58
5. 10-36-201-023-0000	Long Term Care	\$ 149,105.75	\$ 149,105.75
6. 10-36-201-006-0000	Long Term Care	\$ 9,272.91	\$ 9,272.91
7. 10-36-201-007-0000	Long Term Care	\$ 9,324.37	\$ 9,324.37
8. 10-36-201-008-0000	Long Term Care	\$ 9,286.56	\$ 9,286.56
9. 10-36-201-009-0000	Long Term Care	\$ 9,254.40	\$ 9,254.40
10.		\$	\$
TOTALS		\$ 349,928.72	\$ 349,928.72

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: 67,656 B. General Construction Type: Exterior Brick Frame Steel & Concrete Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) 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:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	420,806	1973-1978	\$ 300,000	1
2					2
3	TOTALS	420,806		\$ 300,000	3

Facility Name & ID Number Buckingham Pavilion

0019836

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			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	247			1975	\$ 1,042,681	\$	40	\$	\$	\$ 1,042,681	4	
5				1979	1,953,104		30			1,953,104	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1975	334		20	17	17	102	9	
10	Various			1975	1,973		20	99	99	594	10	
11	Various			1980	3,208		20	161	161	966	11	
12	Various			1981	2,800		20	140	140	840	12	
13	Various			1983	8,923		20	261	261	5,979	13	
14	Various			1984	2,865		20	143	143	1,347	14	
15	Various			1985	19,459		20	973	973	9,730	15	
16	Various			1989	68,100		20	2,213	2,213	54,835	16	
17	Various			1990	9,307		20	465	465	6,978	17	
18	Various			1992	8,110		20	406	406	6,897	18	
19	Various			1996	3,565		20	178	178	3,756	19	
20	Various			1997	32,746		20	1,374	1,374	35,493	20	
21	Various			1998	117,974		20			117,974	21	
22	Various			1999	181,587		20			181,587	22	
23	Various			2000	19,095		20			19,095	23	
24	Various			2001	190,710		20			190,710	24	
25	Various			2002	57,699		20			57,699	25	
26	Various			2003	11,459		20			11,459	26	
27	Various			2004	34,806		20	524	524	34,806	27	
28	Various			2005	32,170		20			32,170	28	
29	Various			2006	22,524		20	66	66	22,518	29	
30	Various			2007	9,175		20	458	458	8,481	30	
31	Various			2008	8,100		20	405	405	6,966	31	
32	Various			2009	41,874		20	200	200	41,174	32	
33	Various			2010	208,877		20			208,877	33	
34	Various			2011	142,411		20	3,929	3,929	139,114	34	
35	Various			2012	17,687		20	884	884	18,284	35	
36	Various			2013	46,229		20	2,311	2,311	28,616	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 Buckingham Pavilion

0019836

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	
37	Various	2014	\$ 34,137	\$	20	\$ 1,707	\$ 1,707	\$ 19,443	37
38	Various	2015	3,900		20	195	195	2,113	38
39	Various	2016	41,923		20	2,096	2,096	20,220	39
40	Various	2017	53,100		20	2,655	2,655	21,934	40
41	Various	2018	35,304		20	1,766	1,766	13,436	41
42	Various	2019	10,800		20	540	540	3,780	42
43	Circulating Pump Motor Repair	2020	2,853		20	143	143	858	43
44	Elevator Work-Install Phones,Cables, Stop & Key Switches	2020	10,949		20	547	547	3,282	44
45	A/C Repair-Valve Replacement	2020	4,180		20	299	299	1,344	45
46	Cedar Library Repairs	2020	3,000		20	150	150	900	46
47	A/C Repairs West & East Units-Replaced Filter Dryer	2020	3,851		20	193	193	1,158	47
48	Co Detector Alarm Replacement in East Boiler Room	2021	3,880		20	194	194	970	48
49	Garbage Disposal System	2021	2,826		20	141	141	705	49
50	Replace Existing Sewer Unit-Aqua City Plumbing	2022	7,000		20	350	350	1,400	50
51	Repair East Side Boiler	2022	5,007		20	250	250	1,000	51
52	Epoxy Flooring Installation in Dining Room	2023	12,687		20	634	634	1,902	52
53	Boiler Installation	2023	26,978		20	1,349	1,349	4,047	53
54	Boiler-Cb-23000 Part Repair	2023	5,250		20	263	263	789	54
55	Walk In Cooler-New Defrost Clock,Expansion Valve,Condensing	2023	4,201		20	210	210	630	55
56	Custom Made Ark Cabinets Wiyj Built In Bookcases	2023	34,500		20	1,725	1,725	5,175	56
57	Elevator Modernization Project	2024	80,000		20	4,000	4,000	8,000	57
58	Elevator Modernization Project	2025	88,410		20	4,421	4,421	4,421	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Financial Statement Depreciation			142,430			(142,430)		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,774,288	\$ 142,430		\$ 39,035	\$ (103,395)	\$ 4,360,339	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	\$ 164,439	\$	\$ 16,444	\$ 16,444	10	\$ 120,717	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	748,042					748,042	73
74								74
75	TOTALS	\$ 912,481	\$	\$ 16,444	\$ 16,444		\$ 868,759	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	2016 Toyota RAV4	2018	\$ 23,083	\$	\$ 4,617	\$ 4,617	5	\$ 23,083	76
77	Facility	2026 Toyota	2025	35,750		7,150	7,150	5		77
78	Facility	2026 Honda	2025	46,487		9,297	9,297	5		78
79										79
80	TOTALS			\$ 105,320	\$	\$ 21,064	\$ 21,064		\$ 23,083	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)	\$ 6,092,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,430	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,543	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,887)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,252,181	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

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

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.

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	142,206		258,736			400,942	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				129,720		129,720	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					18,184		18,184	12
13	Other (specify):									13
14	TOTAL			\$ 142,206		\$ 258,736	\$ 147,904		\$ 548,846	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	\$ 2,130,387	\$ 2,130,387	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,166,204	2,166,204	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	202,910	202,910	6
7	Other Prepaid Expenses	183,160	183,160	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,682,661	\$ 4,682,661	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		1,042,681	14
15	Leasehold Improvements, at Historical Cost	986,364	2,939,468	15
16	Equipment, at Historical Cost	1,077,423	1,077,423	16
17	Accumulated Depreciation (book methods)	(1,800,924)	(4,796,709)	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)	\$ 262,863	\$ 562,863	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,945,524	\$ 5,245,524	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 292,923	\$ 292,923	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,075	46,075	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,147	4,147	31
32	Accrued Real Estate Taxes(Sch.IX-B)	356,928	356,928	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Income</u>	979,213	929,213	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,679,286	\$ 1,629,286	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)	\$ 1,679,286	\$ 1,629,286	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,266,238	\$ 3,616,238	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,945,524	\$ 5,245,524	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,856,767	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,856,767	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	909,471	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	(500,000)	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)	\$ 409,471	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,266,238	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Buckingham Pavilion

0019836

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	\$ 12,172,992	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,172,992	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,172,992	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,620,852	31
32	Health Care	3,872,753	32
33	General Administration	3,224,907	33
	B. Capital Expense		
34	Ownership	1,361,707	34
	C. Ancillary Expense		
35	Special Cost Centers	548,846	35
36	Provider Participation Fee	634,456	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,263,521	40
41	Income before Income Taxes (line 30 minus line 40)**	909,471	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 909,471	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,408,361.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,067,860.00	45
46	MMAI-Medicaid is the Primary Payer	272,675.00	46
47	MMAI-Medicare is the Primary Payer	90,350.00	47
48	Private Pay	3,191,883.00	48
49	Medicare Part A	1,862,166.00	49
50	Other-(specify) Medicare-B	371,364.00	50
51	Other-(specify) Medicare Advantage	908,333.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,172,992	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,555	25,730	1,093,216	42.49	3
4	Licensed Practical Nurses	7,522	7,711	331,109	42.94	4
5	CNAs & Orderlies	56,827	58,866	1,258,729	21.38	5
6	CNA Trainees					6
7	Licensed Therapist	3,744	3,808	142,206	37.34	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,800	2,840	51,189	18.02	10
11	Social Service Workers	2,080	2,175	73,679	33.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,222	20,765	365,949	17.62	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,704	17,954	307,667	17.14	18
19	Laundry	3,926	4,000	68,789	17.20	19
20	Administrator	2,080	2,160	380,275	176.05	20
21	Assistant Administrator	4,160	4,320	709,913	164.33	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,366	9,590	584,093	60.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,986	159,919	\$ 5,366,814 *	\$ 33.56	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		\$		35
36	Medical Director	Monthly	45,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	205	15,455	10-3	38
39	Pharmacist Consultant	Monthly	13,979	10-3	39
40	Physical Therapy Consultant	Monthly	11,906	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)	205	\$ 87,040		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	20,840	729,393	10-3	52
53	TOTAL (lines 50 - 52)	20,840	\$ 729,393		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Eric Stern	Administrator	0	\$ 597,500	Workers' Compensation Insurance		\$ 28,304	IDPH License Fee	\$ 1,990	
Sheldon Stern	Administrator	25.5	380,275	Unemployment Compensation Insurance		17,656	Advertising: Employee Recruitment	19,823	
Steven Gross	Financial Mgr	0	112,413	FICA Taxes		374,249	Health Care Worker Background Check		
				Employee Health Insurance		73,392	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
							Various	2,712	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 1,090,188						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 493,601	TOTAL (agree to Sch. V, line 20, col. 8) \$ 24,525		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services							Description Amount		
Vendor/Payee	Type	Amount		Description	Line #	Amount			
Mendel Schneider CPA	Accounting	\$ 21,500				\$	Out-of-State Travel	\$	
Marcum LLP	Accounting	10,437							
Personnel Planners	UC Tax Consultant	1,250							
Stout	Appraisal	5,514					In-State Travel		
J Slatus	Immigration Attorneys	8,740							
Much Shelist	Legal	2,307							
Guided Care	Managcare Cons	2,000							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Seminar Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 51,748						

*** Attach copy of IMRF notifications**

****See instructions.**

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
	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.

	Total
- (4)

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

	Total
- (5)

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

\$ 73,610 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.

\$ 634,456

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

Travel and Transportation

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

No If YES, attach a complete explanation.

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

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

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

d. Have vehicle usage logs been maintained?

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

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

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

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (13)

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

Firm Name: 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.