

		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: <u>0058487</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																														
Facility Name: <u>Celebrate Sr Living Moline</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																														
Address: <u>7300 34th Avenue</u> <u>Moline</u> <u>61265</u> Number City Zip Code																																
County: <u>Rock Island</u>																																
Telephone Number: <u>(309) 792-5940</u> Fax # <u>(309) 792-5975</u>																																
HFS ID Number: _____																																
Date of Initial License for Current Owners: <u>11/30/2023</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Maria DeFrenza</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u></td></tr><tr><td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Maria DeFrenza</u>	(Title) <u>CFO</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u>	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>																				
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Type of Ownership:																																
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☐	State																															
☐	County																															
☐	Other _____																															
IRS Exemption Code _____																																
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																														
Name: <u>Daniel S. Gaafar</u>																																
Telephone Number: <u>(317) 237-5500</u> Email Address: _____																																

Facility Name & ID Number Celebrate Sr Living Moline # 0058487 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 <u>N/A</u>					
	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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,961	11,923	4,062	38	3,208	1,092	10,418	35,702	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,961	11,923	4,062	38	3,208	1,092	10,418	35,702	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.51%

D. How many bed reserve days during this year were paid by the Department? N/A (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) N/A

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 11/30/2023

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/30/2023 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 120

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Celebrate Sr Living Moline # 0058487 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	385,628	21,291	19,942	426,861		426,861		426,861			1
2	Food Purchase		294,952		294,952		294,952	(141)	294,811			2
3	Housekeeping	250,916	28,945		279,861		279,861		279,861			3
4	Laundry	66,661	30,241		96,902		96,902		96,902			4
5	Heat and Other Utilities			303,081	303,081		303,081		303,081			5
6	Maintenance	64,364	23,094	111,725	199,183		199,183		199,183			6
7	Other (specify):*											7
8	TOTAL General Services	767,569	398,523	434,748	1,600,840		1,600,840	(141)	1,600,699			8
	B. Health Care and Programs											
9	Medical Director			29,000	29,000		29,000		29,000			9
10	Nursing and Medical Records	3,907,083	221,162	9,976	4,138,221		4,138,221		4,138,221			10
10a	Therapy	337,936	2,811		340,747		340,747		340,747			10a
11	Activities	104,717	2,205		106,922		106,922		106,922			11
12	Social Services	109,724		9,100	118,824		118,824		118,824			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			7,520	7,520		7,520		7,520			15
16	TOTAL Health Care and Programs	4,459,460	226,178	55,596	4,741,234		4,741,234		4,741,234			16
	C. General Administration											
17	Administrative	157,263			157,263		157,263		157,263			17
18	Directors Fees											18
19	Professional Services			572,998	572,998		572,998	(521,006)	51,992			19
20	Dues, Fees, Subscriptions & Promotions			26,119	26,119		26,119		26,119			20
21	Clerical & General Office Expenses	222,054	18,094	224,849	464,997		464,997	847	465,844			21
22	Employee Benefits & Payroll Taxes			621,689	621,689		621,689	175,954	797,643			22
23	Inservice Training & Education							987	987			23
24	Travel and Seminar			12,338	12,338		12,338	(3,554)	8,784			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			141,065	141,065		141,065	977	142,042			26
27	Other (specify):* Ded. Benefits Expense	914			914		914	106	1,020			27
28	TOTAL General Administration	380,231	18,094	1,599,058	1,997,383		1,997,383	(345,689)	1,651,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,607,260	642,795	2,089,402	8,339,457		8,339,457	(345,830)	7,993,627			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			35,158	35,158		35,158	44	35,202			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							285	285			32
33	Real Estate Taxes			108,867	108,867		108,867		108,867			33
34	Rent-Facility & Grounds			730,853	730,853		730,853	13,060	743,913			34
35	Rent-Equipment & Vehicles			45,537	45,537		45,537		45,537			35
36	Other (specify):*							19	19			36
37	TOTAL Ownership			920,415	920,415		920,415	13,408	933,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			29,172	29,172		29,172		29,172			38
39	Ancillary Service Centers		270,560		270,560		270,560		270,560			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			605,137	605,137		605,137		605,137			42
43	Other (specify):* Bad Debt			105,071	105,071		105,071	(105,071)				43
44	TOTAL Special Cost Centers		270,560	739,380	1,009,940		1,009,940	(105,071)	904,869			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,607,260	913,355	3,749,197	10,269,812		10,269,812	(437,493)	9,832,319			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	(62)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(141)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,637)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,289)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,071)	43		24
25	Fund Raising, Advertising and Promotional	(12,008)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,208)		\$	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)	(301,285)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (301,285)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (437,493)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$		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
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		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.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Elevate Housing Foundation	100%	Celebrate Senior Living Niles	Niles, IL			
		Celebrate Senior Living Fort Wayne	Fort Wayne, IN			
		Pillar of Cedar Valley	Waterloo, IA			

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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	\$ 534,591	Provident Healthcare Management		\$ 13,585	\$ (521,006)	1
2	V	21	Clerical & General Office Expenses		Provident Healthcare Management		28,144	28,144	2
3	V	22	Employee Benefits & Payroll Taxes		Provident Healthcare Management		175,954	175,954	3
4	V	23	Training and Education		Provident Healthcare Management		987	987	4
5	V	24	Travel and Seminar		Provident Healthcare Management		83	83	5
6	V	26	Insurance - Prop. Liab. Malpractice		Provident Healthcare Management		977	977	6
7	V	27	Recruiting		Provident Healthcare Management		106	106	7
8	V	30	Depreciation		Provident Healthcare Management		44	44	8
9	V	32	Interest		Provident Healthcare Management		347	347	9
10	V	34	Rent - Facility & Grounds		Provident Healthcare Management		13,060	13,060	10
11	V	36	Other		Provident Healthcare Management		19	19	11
12	V								12
13	V								13
14	Total			\$ 534,591			\$ 233,306	\$ * (301,285)	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.

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	NOT APPLICABLE								\$		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 Celebrate Sr Living Moline # 0058487 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 Provident Healthcare Management
Street Address 7101 N. Cicero Ave, Suite 100
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (224) 470-6513
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Professional Services				\$ 13,585	\$		\$ 13,585	1
2	21	Clerical & General Office Expenses				28,144			28,144	2
3	22	Employee Benefits & Payroll Taxes				175,954			175,954	3
4	23	Training and Education				987			987	4
5	24	Travel and Seminar				83			83	5
6	26	Insurance - Prop. Liab. Malpractice				977			977	6
7	27	Recruiting				106			106	7
8	30	Depreciation				44			44	8
9	32	Interest				347			347	9
10	34	Rent - Facility & Grounds				13,060			13,060	10
11	36	Other				19			19	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					\$ 233,306	\$		\$ 233,306	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	GS Capital Funding, LLC		X	Working Capital	N/A	N/A	Various	Various	N/A			285	8
9	TOTAL Facility Related						\$				\$	285	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$	285	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.		\$	2,011	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.)				\$	118,237	2
3. Under or (over) accrual (line 2 minus line 1).				\$	116,226	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	(7,359)	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.				\$	108,867	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020	106,610	9			
	2021	107,156	10			
	2022	112,848	11			
	2023	110,910	12			
	2024	118,237	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Celebrate Sr Living Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0058487

CONTACT PERSON REGARDING THIS REPORT Maria DeFrenza

TELEPHONE (309) 792-5940 FAX #: (309) 792-5975

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. 17-12-406-001	Long Term Care Property	\$ 25,860.32	\$ 25,860.32
2. 17-12-406-002	Long Term Care Property	\$ 92,376.24	\$ 92,376.24
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 118,236.56	\$ 118,236.56

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: 39,200B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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.

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

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility Land			\$	1
2	Nursing Facility				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	120				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	SIGNAGE			2023	7,129	713	10	713	(0)	713
10										10
11	RYAN AND ASSOCIATES - REPLACE THE COOLING TOWER			2025	150,837	1,257	10	1,257	(0)	1,257
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 157,966	\$ 1,970		\$ 1,970	\$ (0)	\$ 1,970	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	\$71,447	\$19,891	\$19,891	\$	3	\$20,786	71
72	Current Year Purchases	78,875	13,297	13,297		3	13,297	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$150,322	\$33,188	\$33,188	\$		\$34,083	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)	\$308,288	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$35,158	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$35,158	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$36,053	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: CCG Barbados, LLC
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:			11/30/2023	\$ 730,829			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 730,829			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 11/30/2023
Ending 11/30/2032

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2026	\$ 664,161
13.	12/31/2027	\$ 618,893
14.	12/31/2028	\$ 634,369

* 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	10A-1	3084	hrs	\$	121,136		\$	3,084	\$	121,136	1	
2	Licensed Speech and Language Development Therapist	10A-1	172	hrs		13,611			172		13,611	2	
3	Licensed Recreational Therapist			hrs								3	
4	Licensed Physical Therapist	10A-1	2517	hrs		93,813			2,517		93,813	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			238,976			238,976		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10	
11	Academic Education			hrs								11	
12	Other (specify): <u>X-Ray/Oxygen</u>	39, 2					4,950			4,950		12	
13	Other (specify): <u>Lab</u>	39, 2					26,634			26,634		13	
14	TOTAL				\$	228,560		\$	270,560	5,773	\$	499,120	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$359,950	\$359,950	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	912,199	912,199	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	226,697	226,697	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(260,059)	(260,059)	8
9	Other(specify): Vendor Deposit	175,000	175,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,413,787	\$1,413,787	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	157,966	157,966	15
16	Equipment, at Historical Cost	150,322	150,322	16
17	Accumulated Depreciation (book methods)	(36,053)	(36,053)	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) Escrow & Acquisition	54,422	54,422	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$326,657	\$326,657	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,740,444	\$1,740,444	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$586,658	\$586,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	(55,786)	(55,786)	29
30	Accrued Salaries Payable	214,271	214,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,829	31,829	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$776,972	\$776,972	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)	\$776,972	\$776,972	46
47	TOTAL EQUITY(page 18, line 24)	\$963,472	\$963,472	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,740,444	\$1,740,444	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (210,351)	1
2	Restatements (describe):	751,836	2
3	PY Adjustment		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 541,485	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	421,987	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)	\$ 421,987	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)	\$ 963,472	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Celebrate Sr Living Moline

0058487

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	\$ 10,371,627	1
2	Discounts and Allowances for all Levels	(3,236,454)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,135,173	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,112,770	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,112,770	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	230,015	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,363	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 232,378	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	23,551	28
28a	Quality Incentives	187,865	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 211,416	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,691,799	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,600,841	31
32	Health Care	4,741,235	32
33	General Administration	1,997,382	33
	B. Capital Expense		
34	Ownership	920,414	34
	C. Ancillary Expense		
35	Special Cost Centers	270,560	35
36	Provider Participation Fee	605,137	36
	D. Other Expenses (specify):		
37	<u>Bad Debt Expense</u>	105,071	37
38	<u>Medically Necessary Transportation</u>	29,172	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,269,812	40
41	Income before Income Taxes (line 30 minus line 40)**	421,987	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 421,987	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 991,474.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,382,854.00	45
46	MMAI-Medicaid is the Primary Payer	811,805.00	46
47	MMAI-Medicare is the Primary Payer	7,594.00	47
48	Private Pay	641,130.00	48
49	Medicare Part A	218,240.00	49
50	Other-(specify) <u>Medicare Advantage & Hospice</u>	2,082,076.00	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)	\$ 7,135,173	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	1,899	2,088	\$ 123,745	\$ 59.26	1
2	Assistant Director of Nursing	2,486	2,742	129,027	47.06	2
3	Registered Nurses	9,935	10,787	498,756	46.24	3
4	Licensed Practical Nurses	25,643	27,673	1,155,503	41.76	4
5	CNAs & Orderlies	63,742	68,005	1,664,323	24.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,147	12,164	422,439	34.73	8
9	Activity Director	2,214	2,395	63,826	26.65	9
10	Activity Assistants	2,548	2,557	40,891	15.99	10
11	Social Service Workers	4,018	4,313	109,724	25.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,594	22,070	385,628	17.47	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,209	64,364	29.14	17
18	Housekeepers	14,504	15,367	250,916	16.33	18
19	Laundry	3,849	4,204	66,661	15.86	19
20	Administrator	2,038	2,143	157,263	73.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,176	11,039	274,187	24.84	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	534	684	18,290	26.74	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	4,552	4,812	181,717	37.76	33
34	TOTAL (lines 1 - 33)	181,872	195,252	\$ 5,607,260 *	\$ 28.72	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	570	\$ 19,942	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	200	9,976	30-3	38
39	Pharmacist Consultant	150	7,520	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	260	9,100	12-3	45
46	Other(specify) Executive Consultant	87	4,337	19-3	46
47	Purchasing Consultant	253	8,872	20-3	47
48					48
49	TOTAL (lines 35 - 48)	1,520	\$ 59,747		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				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberCelebrate Sr Living Moline# 0058487Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Tara Wassell

Administrator

0

\$ 157,263

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

(List each licensed administrator separately.)

\$ 157,263

B. Administrative - Other

Description

Amount

\$

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

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

GS Management

Mgmt/Professional Fees

\$ 534,591

Audio Interpreting

Consulting Services

871

Consulting

Consulting Services

3,466

Legal Fees

Legal Fees

139

Professional Fees

Professional Fees

17,692

Accounting Fees

Accounting Fees

16,239

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

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

\$ 572,998

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 40,418

Unemployment Compensation Insurance

31,048

FICA Taxes

420,415

Employee Health Insurance

128,325

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Expenses

1,483

Employee Benefits & Payroll Taxes

175,954

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

\$ 797,643

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

3,315

Association Dues (total from pg 22, #4)

2,846

Consulting Fees

8,872

Other License, Fees, and Dues

11,086

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

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

\$ 26,119

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Mileage

1,012

Seminar Expense

Education & Seminars

7,689

Travel & Seminar

83

Entertainment Expense

()

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

TOTAL

\$ 8,784

* 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.

\$ 61,047 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.

\$ 605,137

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.

\$ N/A

Has any meal income been offset against related costs?

NO

Indicate the amount.

\$
- (12)

Travel and Transportation

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

NO

If YES, attach a complete explanation.

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

NO

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

\$ N/A

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

N/A

d. Have vehicle usage logs been maintained?

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?

YES

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

NO

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

\$ N/A
- (13)

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

Firm Name: 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.