

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0053553</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>Central Nursing Home</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>2450 N Central Ave</u> <u>Chicago</u> <u>60639</u> Number City Zip Code																																		
County: <u>Cook</u>																																		
Telephone Number: <u>773-889-1333</u> Fax # <u>773-889-1516</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>05/01/15</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountant's Report Attached</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Illinois 60076</u></td></tr><tr><td>(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>See Accountant's Report Attached</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Illinois 60076</u>	(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>																					
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Type of Ownership:																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☒</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☐</td><td>"Sub-S" Corp.</td></tr><tr><td>☒</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☒	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☐	"Sub-S" Corp.	☒	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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☐	County																																	
☐	Other _____																																	
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																
Name: <u>Mendel S Schneider</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																
Telephone Number: <u>847-933-1274</u>		2200 Churchill Rd.																																
Email Address: _____		Springfield, IL 62702-3406																																
		Phone # (217) 782-1630																																

Facility Name & ID Number Central Nursing Home # 0053553 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	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>89,425</u>	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	<u>245</u>	TOTALS	<u>245</u>	<u>89,425</u>	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	7,725	45,988	6,083	337	1,691	1,233	3,959	67,016	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,725	45,988	6,083	337	1,691	1,233	3,959	67,016	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 74.94%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ 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 05/01/15

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/01/15 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 245

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Central Nursing Home # 0053553 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	494,828	18,324	22,943	536,095	(30,000)	506,095		506,095			1
2	Food Purchase		473,166		473,166		473,166	(163)	473,003			2
3	Housekeeping	416,699	25,515	22,904	465,118		465,118		465,118			3
4	Laundry		8,279		8,279		8,279		8,279			4
5	Heat and Other Utilities			225,594	225,594		225,594	4,862	230,456			5
6	Maintenance	56,474		79,837	136,311		136,311	4,272	140,583			6
7	Other (specify):*											7
8	TOTAL General Services	968,001	525,284	351,278	1,844,563	(30,000)	1,814,563	8,971	1,823,534			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,887,413	112,305	642,609	5,642,327		5,642,327		5,642,327			10
10a	Therapy											10a
11	Activities	180,481			180,481		180,481		180,481			11
12	Social Services	130,013		10,712	140,725		140,725		140,725			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,197,907	112,305	653,321	5,963,533		5,963,533		5,963,533			16
	C. General Administration											
17	Administrative	164,649		1,657,496	1,822,145		1,822,145	(1,635,288)	186,857			17
18	Directors Fees											18
19	Professional Services			124,200	124,200		124,200	28,330	152,530			19
20	Dues, Fees, Subscriptions & Promotions			88,802	88,802		88,802	(34,394)	54,408			20
21	Clerical & General Office Expenses	277,327	17,316	239,208	533,851		533,851	1,016,655	1,550,506			21
22	Employee Benefits & Payroll Taxes			799,847	799,847	30,000	829,847		829,847			22
23	Inservice Training & Education											23
24	Travel and Seminar			386	386		386		386			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,441	82,441		82,441	154,416	236,857			26
27	Other (specify):* Allocated Benefits							58,071	58,071			27
28	TOTAL General Administration	441,976	17,316	2,992,380	3,451,672	30,000	3,481,672	(412,210)	3,069,462			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,607,884	654,905	3,996,979	11,259,768		11,259,768	(403,239)	10,856,529			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			67,537	67,537		67,537	128,645	196,182			30
31	Amortization of Pre-Op. & Org.							487,610	487,610			31
32	Interest							600,857	600,857			32
33	Real Estate Taxes			72,361	72,361		72,361	626,193	698,554			33
34	Rent-Facility & Grounds			1,998,834	1,998,834		1,998,834	(1,998,834)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			185,596	185,596		185,596	(185,596)				36
37	TOTAL Ownership			2,324,328	2,324,328		2,324,328	(341,125)	1,983,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,795	606,188	670,983		670,983		670,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			826,818	826,818		826,818		826,818			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,795	1,433,006	1,497,801		1,497,801		1,497,801			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,607,884	719,700	7,754,313	15,081,897		15,081,897	(744,364)	14,337,533			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	23,184	30		9
10	Interest and Other Investment Income	(15,209)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	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	(26,778)	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	(185,596)	36		24
25	Fund Raising, Advertising and Promotional	(17,727)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(28,470)	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)	\$ (250,759)		\$	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)	(476,938)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (476,938)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (727,697)		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	\$ (16,667)	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
11				11
12				12
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,667)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

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

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	\$ 1,998,834	Novo Investors LLC	100.00%	\$	\$ (1,998,834)	1
2	V	30	Depreciation		Novo Investors LLC		105,461	105,461	2
3	V	31	Amortization		Novo Investors LLC		487,610	487,610	3
4	V	19	Professional Fees		Novo Investors LLC		8,500	8,500	4
5	V	33	Real Estate Tax		Novo Investors LLC		609,428	609,428	5
6	V	32	Interest		Novo Investors LLC		616,066	616,066	6
7	V	26	Insurance		Novo Investors LLC		150,264	150,264	7
8	V	21	Office				77	77	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,998,834			\$ 1,977,406	\$ * (21,428)	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	21	Payroll	\$		100.00%	\$ 523,367	\$ 523,367	15
16	V	27	Payroll Taxes				58,071	58,071	16
17	V	33	Real Estate Tax				16,765	16,765	17
18	V	5	Utilities				4,862	4,862	18
19	V	6	Repairs & Maintenance				4,272	4,272	19
20	V	26	Insurance				4,152	4,152	20
21	V	19	Professional Fees				19,830	19,830	21
22	V	21	Office				40,402	40,402	22
23	V	17	Marvin Mermelstein				22,208	22,208	23
24	V	21	Doreen Mermelstein				3,852	3,852	24
25	V	21	Jacob Mermelstein				152,564	152,564	25
26	V	21	Joel Mermelstein				152,893	152,893	26
27	V	21	Jeffrey Mermelstein				198,748	198,748	27
28	V	17	Management Fees	1,657,496				(1,657,496)	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			\$ 1,657,496			\$ 1,201,986	\$ * (455,510)	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Paul House & Health Care Ctr	Chicago			Novo Investors LLC	Lincolnwood	Bldg Rental	1
2	Winston Manor Nursing Ctr	Chicago			Nivram Mgmt	Lincolnwood	Mgmt Co	2
3	Balmoral Nursing Home	Chicago						3
4								4
5								5
6								6
7								7
8								8
9								9
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29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marvin Mermelstein		Adm	50.00	45,594	10	25.00	Salary	\$ 22,208	17	1
2	Doreen Mermelstein		Clerical	0.00	7,908	10	25.00	Salary	3,852	21	2
3	Jacob Mermelstein		Clerical	0.00	313,222	10	25.00	Salary	152,564	21	3
4	Joel Mermelstein		Clerical	0.00	313,898	10	25.00	Salary	152,893	21	4
5	Jeffrey Mermelstein		Clerical	0.00	408,043	10	25.00	Salary	198,748	21	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 530,265		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 Central Nursing Home # 0053553 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 Nivram Mgmt Co
Street Address 6500 N Hamlin
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847-679-7484
Fax Number (847-679-7494

	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	21	Payroll	Resident Beds	748	4	\$ 1,597,872	\$ 1,597,872	245	\$ 523,367	1
2	27	Payroll Taxes	Resident Beds	748	4	177,295		245	58,071	2
3	33	Real Estate Tax	Resident Beds	748	4	51,185		245	16,765	3
4	5	Utilities	Resident Beds	748	4	14,844		245	4,862	4
5	6	Repair & Maintenance	Resident Beds	748	4	13,043		245	4,272	5
6	26	Insurance	Resident Beds	748	4	12,677		245	4,152	6
7	19	Professional Fees	Resident Beds	748	4	60,541		245	19,830	7
8	21	Office	Resident Beds	748	4	123,350		245	40,402	8
9	17	Marvin Mermelstein	Resident Beds	748	4	67,802	67,802	245	22,208	9
10	21	Doreen Mermelstein	Resident Beds	748	4	11,760	11,760	245	3,852	10
11	21	Jacob Mermelstein	Resident Beds	748	4	465,786	230,442	245	152,564	11
12	21	Joel Mermelstein	Resident Beds	748	4	466,791	231,447	245	152,893	12
13	21	Jeffrey Mermelstein	Resident Beds	748	4	606,791	371,447	245	198,748	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					\$ 3,669,737	\$ 2,510,770		\$ 1,201,986	25

Facility Name & ID Number Central Nursing Home # 0053553 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	Capital One		X	Mortgage	\$153,947.00	05/01/15	\$ 21,250,000	\$ 15,742,257		3.8500	\$ 616,066	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$153,947.00		\$ 21,250,000	\$ 15,742,257			\$ 616,066	9	
	B. Non-Facility Related*												
10	Interest Income		X								(15,209)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (15,209)	14	
15	TOTALS (line 9+line14)						\$ 21,250,000	\$ 15,742,257			\$ 600,857	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.)

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 Central Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053553

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE 847-715-2522 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. 13-29-431-013-0000		\$ 31,853.11	\$ 31,853.11
2. 13-29-431-014-0000		\$ 80,533.09	\$ 80,533.09
3. 13-29-431-015-0000		\$ 80,533.09	\$ 80,533.09
4. 13-29-431-016-0000		\$ 80,533.09	\$ 80,533.09
5. 13-29-431-017-0000		\$ 80,533.09	\$ 80,533.09
6. 13-29-431-018-0000		\$ 80,533.09	\$ 80,533.09
7. 13-29-431-019-0000		\$ 80,533.09	\$ 80,533.09
8. 13-29-431-020-0000		\$ 63,893.31	\$ 63,893.31
9. 13-29-431-021-0000		\$ 2,898.50	\$ 2,898.50
10. 13-29-431-022-0000		\$ 2,942.28	\$ 2,942.28
TOTALS		\$ 584,785.74	\$ 584,785.74

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 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2024 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2025 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2024.

Please complete the Real Estate Tax Statement below and include it in the 2025 cost report along with a copy of your 2024 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 524-4489.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053553

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE 847-715-2522 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. Allocated From Mgmt Co:		\$	\$
2. 10-35-325-015-0000		\$ 43,099.76	\$ 14,117.00
3. 10-35-325-029-0000		\$ 8,084.94	\$ 2,648.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 51,184.70	\$ 16,765.00

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 NO

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 86,088
- B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 4
- 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? (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? (X) YES NO
If so, please complete the following:

1. Total Amount Incurred: 14,628,243
2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 487,610
4. Dates Incurred: 05/01/15

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

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1	Facility		30,000	2015	\$ 500,000	1	
2						2	
3	TOTALS		30,000		\$ 500,000	3	

Facility Name & ID Number Central Nursing Home

0053553

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	245		2015	1973	\$ 6,076,927	\$ 155,635	39	\$ 155,635	\$	\$ 1,660,780	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cooled Chiller Unit			2015	92,000		7			92,000	9
10	Time Clock Reader			2015	2,574		27.5	94	94	1,303	10
11	HVAC Unit			2015	4,227		7			4,227	11
12	Compressor			2015	8,500		27.5	309	309	3,183	12
13	Elevator Project			2016	10,840		39	278	278	2,757	13
14	Elevator Pump Motor			2016	3,800		39	98	98	928	14
15	Door Project			2015	5,201		27.5	189	189	1,906	15
16	Air Handler			2016	6,470		27.5	236	236	2,318	16
17	Main & Lower Floor Flooring			2016	15,078		27.5	548	548	5,321	17
18	Hot Water Heater			2016	10,750		27.5	392	392	3,655	18
19	Sewer Restoration			2016	11,950		15	759	759	7,863	19
20	Boiler			2016	19,500		7			19,500	20
21	Boiler			2017	22,500		7			22,500	21
22	Security Camera			2017	14,642		7			14,642	22
23	Water Heater			2017	5,700		7			5,700	23
24	Brick Pavers			2017	3,000		15	182	182	1,839	24
25	Ada Signage			2018	5,227		39	135	135	1,077	25
26	Installed New Electrical Panel & Relocated C/R from Old Panel			2018	4,569		39	117	117	936	26
27	New Dryer in Basement			2018	4,422		5	886	886	7,080	27
28	Repipe & Install New Sprinkler in Coolers/Excavate FDC Pipe			2019	33,283		15	2,219	2,219	14,423	28
29	Excavate & Replace Underground FDC Piping/Installed New Fire Alarm										29
30	from Esscoe/Install Roller Shades 92 Cubicle Curtains-1st Floor			2020	16,588		15	1,106	1,106	6,636	30
31	60 LB Rigid Mount Washer			2020	26,449		15	1,763	1,763	10,578	31
32	Air Condensing Unit Installation			2020	8,037		15	536	536	3,216	32
33	Control Solutions-Upgrade Software in 2 Elevators to Comply with			2021	20,833		15	1,389	1,389	6,945	33
34	Chicago Code. This Includes New Allen-Bradley PLCs to										34
35	Replace Existing GE PLCs/Installation of PLC Hardware										35
36	Initial Commissioning & Schmatic Pages of New Hardware										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 Central Nursing Home

0053553

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	Installed Ductless System in Elevator Rooms	2022	\$ 8,000	\$	15	\$ 533	\$ 533	\$ 2,132	37
38	Fire Dervice Upgrade-Software & Hardware Upgrade	2022	57,612		10	5,761	5,761	23,044	38
39	Access Point Installation Surveillance	2022	10,465		15	698	698	2,792	39
40	A/C Replacement 1st,2nd,4th Floors	2023	33,750		15	2,250	2,250	6,750	40
41	Repaving Employee Parking Lot	2024	31,525		15	2,102	2,102	4,204	41
42	Replace Water Heater in Kitchen	2024	13,800		15	920	920	1,840	42
43	Replace Electro Mechanical Line Starter for Elevator 1	2024	5,500		15	367	367	734	43
44	Replace BAD,Side Detector,Edge & Cable-Elevator 1	2024	4,460		15	297	297	594	44
45	Furnished & Installed 2 New A/C Units With Outdoor Condensing	2024	15,500		15	1,033	1,033	2,066	45
46	Install 47 Window treatments in West Wing	2024	15,851		15	1,057	1,057	2,114	46
47	Fox Valley-Fire Pump Replacement	2025	19,354		15	1,290	1,290	1,290	47
48	Kitchen Didn't Have Hot Water-Corrected the Problem	2025	14,000		15	933	933	933	48
49	Equip Intl-Bearing Housing Assembly	2025	6,375		15	425	425	425	49
50	Infiniti Shades-Custom Roller Shades	2025	26,611		15	1,774	1,774	1,774	50
51	Plumbing by Ezra-Fix Laundry Room Leak	2025	14,575		15	972	972	972	51
52	Harrison Mechanical-Replaced Damaged Refractory Panels	2025	3,882		15	259	259	259	52
53	Suburban Elevator-Install New Pistons in Elevator	2025	13,798		15	920	920	920	53
54									54
55									55
56									56
57									57
58									58
59	Financial Statement Depreciation			17,363			(17,363)		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)		\$ 6,728,125	\$ 172,998		\$ 188,462	\$ 15,464	\$ 1,954,156	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	\$77,208	\$	\$7,720	\$7,720	10	\$15,440	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,126,275					1,122,504	73
74								74
75	TOTALS	\$1,203,483	\$	\$7,720	\$7,720		\$1,137,944	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)	\$8,431,608	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$172,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$196,182	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$23,184	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,092,100	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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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	39-3	hrs			606,188			606,188	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				64,795		64,795	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 606,188	\$ 64,795		\$ 670,983	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	\$ 219,808	\$ 372,483	1
2	Cash-Patient Deposits	599,711	599,711	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,379,602	5,379,602	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,084	150,961	6
7	Other Prepaid Expenses	40,761	40,761	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		1,017,784	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,274,966	\$ 7,561,302	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,076,927	14
15	Leasehold Improvements, at Historical Cost	277,516	635,465	15
16	Equipment, at Historical Cost	1,160,862	1,160,862	16
17	Accumulated Depreciation (book methods)	(1,407,743)	(3,604,914)	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): <u>Goodwill</u>		487,610	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,635	\$ 5,255,950	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,305,601	\$ 12,817,252	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,420,884	\$ 1,420,884	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	534,645	534,645	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	370,165	370,165	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,531	21,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)		596,000	32
33	Accrued Interest Payable		50,506	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Acc Mgmt Fees</u>	1,197,643	1,197,643	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,544,868	\$ 4,191,374	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,742,257	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)	\$	\$ 15,742,257	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,544,868	\$ 19,933,631	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,760,733	\$ (7,116,379)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,305,601	\$ 12,817,252	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,929,075	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,929,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,331,658	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	(2,500,000)	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)	\$ 831,658	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)	\$ 2,760,733	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Central Nursing Home

0053553

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	\$ 18,398,346	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,398,346	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***	15,209	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,209	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)	\$ 18,413,555	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,844,563	31
32	Health Care	5,963,533	32
33	General Administration	3,451,672	33
	B. Capital Expense		
34	Ownership	2,324,328	34
	C. Ancillary Expense		
35	Special Cost Centers	670,983	35
36	Provider Participation Fee	826,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,081,897	40
41	Income before Income Taxes (line 30 minus line 40)**	3,331,658	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,331,658	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,664,164.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	10,599,024.00	45
46	MMAI-Medicaid is the Primary Payer	1,329,883.00	46
47	MMAI-Medicare is the Primary Payer	216,279.00	47
48	Private Pay	397,054.00	48
49	Medicare Part A	943,287.00	49
50	Other-(specify) Medicare-B	631,310.00	50
51	Other-(specify) Insurance	46,989.00	51
52	Other-(specify) Veterans	2,570,356.00	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)	\$ 18,398,346	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	2,889	3,049	\$ 206,882	\$ 67.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,534	20,746	888,651	42.83	3
4	Licensed Practical Nurses	26,045	27,120	1,088,478	40.14	4
5	CNAs & Orderlies	102,562	109,075	2,616,854	23.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,846	2,106	47,415	22.51	9
10	Activity Assistants	6,645	6,987	133,066	19.04	10
11	Social Service Workers	4,836	5,043	130,013	25.78	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,068	46,270	22.37	13
14	Head Cook	5,251	5,838	143,377	24.56	14
15	Cook Helpers/Assistants	13,836	15,212	305,181	20.06	15
16	Dishwashers					16
17	Maintenance Workers	2,050	2,226	56,474	25.37	17
18	Housekeepers	19,886	21,363	416,699	19.51	18
19	Laundry					19
20	Administrator	2,080	2,120	164,649	77.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,776	10,376	277,327	26.73	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) MDS	1,543	1,587	86,548	54.54	33
34	TOTAL (lines 1 - 33)	220,726	234,916	\$ 6,607,884 *	\$ 28.13	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 22,943	1-3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	35,657	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	10,712	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,312		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	459	\$ 27,500	10-3	50
51	Licensed Practical Nurses	7,431	408,732	10-3	51
52	Certified Nurse Assistants/Aides	4,878	170,720	10-3	52
53	TOTAL (lines 50 - 52)	12,768	\$ 606,952		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	%	Amount	Description		Amount	Description	Amount	
Lucille Hoffman	Administrator	0	\$ 24,137	Workers' Compensation Insurance	\$	61,197	IDPH License Fee	\$ 1,990	
Doreen Hickman	Administrator	0	140,512	Unemployment Compensation Insurance		38,984	Advertising: Employee Recruitment		
				FICA Taxes		494,744	Health Care Worker Background Check	7,970	
				Employee Health Insurance		204,922	(Indicate # of checks performed _____)		
				Employee Meals		30,000	Patient Background Checks	1,813	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	50,000	
							Net Smart	5,988	
							Various License	3,314	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 164,649						
B. Administrative - Other									
Description			Amount						
Nivram Mgmt Co-Mgmt Fees			\$ 1,657,496						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,657,496						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mendel Schneider CPA	Accounting		\$ 18,200			\$	Out-of-State Travel	\$	
Fred Berkovitz	Legal		904						
Gary Weintraub	Legal		7,596						
Garnet SNF Consulting	Reimbursement Consulting		29,016				In-State Travel		
GCHMO	Case Mgmt		10,664						
O Morgan Staffing	Staffing Placement		27,075						
Dript	IV Consulting		29,045						
R Peel	Medicare		1,700				Seminar Expense		
							Various	386	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)			\$ 124,200				line 24, col. 8)		
							\$ 386		

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	33,333
	33,333 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	16,667
	16,667 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	50,000
	50,000 Total
- (5)

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

\$ 25,000 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.

\$ 826,818

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.

\$ 30,000 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.