

		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: 0018424

Facility Name: Childrens Habilitation Ctr

Address: 121 West 154th St Harvey 60426
Number City Zip Code

County: Cook

Telephone Number: (708) 596-2220 Fax # (708) 596-2258

HFS ID Number:

Date of Initial License for Current Owners: 2/5/1973

Type of Ownership:

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

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

GOVERNMENTAL
State
County
Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

None

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	67	Intermediate/DD	67	24,455	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,455	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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	21,739							21,739	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	21,739							21,739	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.89%

D. How many bed reserve days during this year were paid by the Department? 520 (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 2/15/1973

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

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter certified beds.
number of certified beds 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ 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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	183,222			183,222	(24,174)	159,048		159,048			1
2	Food Purchase		279,123		279,123	(71,564)	207,559		207,559			2
3	Housekeeping	377,862	52,057	34	429,953	(73,752)	356,201		356,201			3
4	Laundry	85,640			85,640		85,640		85,640			4
5	Heat and Other Utilities			144,881	144,881	(35,037)	109,844		109,844			5
6	Maintenance	206,175	123,590	177,357	507,122	(126,254)	380,868		380,868			6
7	Other (specify):*											7
8	TOTAL General Services	852,899	454,770	322,272	1,629,941	(330,781)	1,299,160		1,299,160			8
	B. Health Care and Programs											
9	Medical Director			37,440	37,440	(7,673)	29,767		29,767			9
10	Nursing and Medical Records	6,367,788	850,972	1,216,481	8,435,241	(998,540)	7,436,701		7,436,701			10
10a	Therapy			21	21		21		21			10a
11	Activities	319			319	(42)	277		277			11
12	Social Services	285,927			285,927	(37,725)	248,202		248,202			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Education	548,865	478	495	549,838	(549,838)						15
16	TOTAL Health Care and Programs	7,202,899	851,450	1,254,437	9,308,786	(1,593,818)	7,714,968		7,714,968			16
	C. General Administration											
17	Administrative	376,017			376,017	(102,277)	273,740		273,740			17
18	Directors Fees											18
19	Professional Services			1,664,816	1,664,816	(186,405)	1,478,411	(427,854)	1,050,557			19
20	Dues, Fees, Subscriptions & Promotions			190,521	190,521	(3,313)	187,208	(49,250)	137,958			20
21	Clerical & General Office Expenses	553,722		318,937	872,659	(41,287)	831,372	(167,302)	664,070			21
22	Employee Benefits & Payroll Taxes			1,612,974	1,612,974		1,612,974		1,612,974			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,668	12,668	(1,251)	11,417		11,417			24
25	Other Admin. Staff Transportation			4,478	4,478	(1,780)	2,698		2,698			25
26	Insurance-Prop.Liab.Malpractice			929,872	929,872	(205,596)	724,276		724,276			26
27	Other (specify):*											27
28	TOTAL General Administration	929,739		4,734,266	5,664,005	(541,909)	5,122,096	(644,406)	4,477,690			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,985,537	1,306,220	6,310,975	16,602,732	(2,466,508)	14,136,224	(644,406)	13,491,818			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			255,818	255,818	(62,930)	192,888		192,888			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,892	119,892	(27,881)	92,011	(24,712)	67,299			32
33	Real Estate Taxes			157,646	157,646	(38,173)	119,473		119,473			33
34	Rent-Facility & Grounds			16,700	16,700	(5,134)	11,566		11,566			34
35	Rent-Equipment & Vehicles			24,785	24,785	(7,370)	17,415		17,415			35
36	Other (specify):*											36
37	TOTAL Ownership			574,841	574,841	(141,488)	433,353	(24,712)	408,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,214,853	508,177	1,962,948	3,685,978	(871,106)	2,814,872		2,814,872			39
40	Barber and Beauty Shops			2,880	2,880		2,880		2,880			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,338	224,338		224,338		224,338			42
43	Other (specify):* Allocated Education Expense					3,479,102	3,479,102		3,479,102			43
44	TOTAL Special Cost Centers	1,214,853	508,177	2,190,166	3,913,196	2,607,996	6,521,192		6,521,192			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	10,200,390	1,814,397	9,075,982	21,090,769		21,090,769	(669,118)	20,421,651			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	(24,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(8,400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,258)	21		24
25	Fund Raising, Advertising and Promotional	(47,426)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(433,322)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (669,118)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (669,118)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(1,824)	20	2
3	Non-Allowable Bank Fees	(3,644)	21	3
4	Non-Allowable Lobbying Expense	(36,000)	19	4
5	Non-Allowable Legal Fees	(391,854)	19	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(433,322)		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

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 Ledger	4Amount	5Cost to Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☐ YES☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Theodore Schasetzle IV	Relative	CEO	0.00	None	40	100.00	Salary	\$ 136,681	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 136,681		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

Ending: 2/31/2025

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

Ending: 2/31/2025

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	First Merchants Bank		X	Mortgage	\$35,872.00	3/24/2021	\$ 5,000,000	\$ 3,694,040	3/24/2026	3.5000	\$ 136,754	1	
2				Capitalized Interest							(96,315)	2	
3	Med-One		X	Ventilators	\$17,666.00	5/1/2025	778,359	692,703	4/30/2030	8.0540	42,240	3	
4												4	
5												5	
	Working Capital												
6	IPFS		X	Insurance finance	\$68,510.00	12/31/2024	593,726		9/30/2025	9.1500	22,865	6	
7	IPFS		X	Insurance finance	\$65,601.00	11/1/2025	569,918	508,240	7/31/2026	8.5900	7,611	7	
8	Vendors		X	Vendor Interest							6,737	8	
9	TOTAL Facility Related				\$187,649.00		\$ 6,942,003	\$ 4,894,983			\$ 119,892	9	
	B. Non-Facility Related*												
10	Interest Income		X								(24,712)	10	
11	Education Allocation										(27,208)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (51,920)	14	
15	TOTALS (line 9+line14)						\$ 6,942,003	\$ 4,894,983			\$ 67,972	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	119,948	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.)			\$	117,215	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,733)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	123,126	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			\$		
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	120,394	7
Assessed Value from Real Estate Tax Bill:	2024	638,126	8		
Real Estate Tax Bill for Calendar Year:	2020	372,541	9		
	2021	387,365	10		
	2022	396,219	11		
	2023	149,137	12		
	2024	153,486	13		
2025 Accrual = \$157,000*1.05=\$161,160 * 76.40% = \$123,126				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
76.40% of property tax accruals, invoice, and expense related to MCDD healthcare services				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 Childrens Habilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018424

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 29-18-217-055-0000	Long-Term Care Property	\$ 153,485.94	\$ 117,215.30
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 153,485.94	\$ 117,215.30

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? X 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.

Children's Habilitation Center
Real Estate Tax Allocation
Education Services Allocation
1/1/2025-12/31/2025

Total Real Estate Tax Bill	153,485.94
Allocated to Nursing Home	<u>0.76</u>
Nursing Home Real Estate Tax Portion	<u>117,215.26</u>

Education Program Allocated Real Estate Tax Expense 36,270.68

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

20,000

B. General Construction Type:

Exterior

Brick

Frame

Cinder Block

Number of Stories

1
- C.

Does the Operating Entity?

X

(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?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

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

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

Education Program

- F.

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

N/A
- G.

Have you properly capitalized all major repairs and equipment purchases?

Yes
- H.

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- I.

Are you presently operating under a sublease agreement?

No
- J.

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

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

- K.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	46,186	1971	\$ 58,845	1
2	Administration		2021	12,500	2
3	TOTALS	46,186		\$ 71,345	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	67		1973	1973	\$ 818,025	\$		\$		4
5			1974	1974	3,368					5
6			1978	1978	1,701					6
7			1979	1979	1,425					7
8			1980	1980	4,255					8
	Improvement Type**									
9	Various		1988	4,961						9
10	Various		1989	39,620						10
11	Various		1990	87,762						11
12	Various		1991	3,429						12
13	Various		1993	26,119						13
14	Various		1994	20,166						14
15	Various		1995	159,072						15
16	Various		1996	8,175						16
17	Various		1997	20,753						17
18	Various		1998	10,916						18
19	Various		1999	5,438						19
20	Various		2000	1,399						20
21	Various		2001	9,450						21
22	Various		2002	2,000						22
23	Various		2003	71,216						23
24	Various		2005	4,842						24
25	Various		2007	4,459						25
26	Various		2008	96,118						26
27	Various		2009	14,685						27
28	Various		2012	85,028						28
29	Various		2014	31,668						29
30	Various		2015	3,489						30
31	Various		2016	3,155						31
32	Various		2018	259,898						32
33	Various		2019	54,314						33
34	Various		2020	48,000						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

Facility Name & ID Number Childrens Habilitation Ctr

0018424

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Historical Asset Refunded (2018)		\$ (38,265)	\$		\$	\$	\$	37
38			38,265						38
39	Winchester House Acquisition	2000	1,000						39
40	Winchester House Acquisition	2021	70,898						40
41	Headwalls - Entire Facility	2022	234,710						41
42	Roof New Roof Entire Facility	2022	746,586						42
43	HVAC Roof units Entire Facility	2022	348,907						43
44	Elevator Repair Work	2022	860						44
45	Gas Service Move Gas Service for entire Facility	2022	125,450						45
46	Dryer Exhaust - Laundry Room	2022	33,603						46
47	Modular Service Co (Headwalls Room 110 and 113)	2025	9,706						47
48	Modular Service Co (Headwalls Room 110 and 113)	2025	1,715						48
49	Meany (Headwalls Room 110 and 113)	2025	1,044						49
50	Helm Service (Headwalls Room 110 and 113)	2025	13,603						50
51	Meany (Headwalls Room 110 and 113)	2025	5,895						51
52									52
53	Depreciation			258,818		258,818		4,369,028	53
54	Education Allocation			(60,373)		(60,373)			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)		\$ 3,498,883	\$ 198,445		\$ 198,445	\$	\$ 4,369,028	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	\$ 2,261,124	\$	\$	\$		\$	71
72	Current Year Purchases	913,245						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,174,369	\$	\$	\$		\$	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		Chevy 4500 Bus	2009	\$ 106,252	\$	\$	\$		\$	76
77		Maintenance Truck	2021	28,104						77
78										78
79										79
80	TOTALS			\$ 134,356	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,878,953	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 198,445	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,445	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,369,028	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	Construction In Progress	\$ 3,948,065	92
93			93
94			94
95		\$ 3,948,065	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: _____
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	Storage				16,700			5
6	Education Allocation				(5,010)			6
7	TOTAL				\$ 11,690			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: \$ 17,592 Description: Copy Machines (\$24,785 Less Education Allocation -\$7,193)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	

(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.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1	hrs	\$ 179,796		\$	\$		\$ 179,796	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	31,809					31,809	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	204,394					204,394	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				26,235		26,235	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Med/RT Supply/O2/RT</u>	39-2					481,942		481,942	12
13	Other (specify): <u>RT Sal/Ctrct Labor</u>	39-1/39-3		798,854		1,962,948			2,761,802	13
14	TOTAL			\$ 1,214,853		\$ 1,962,948	\$ 508,177		\$ 3,685,978	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	\$ 3,050,778	\$	1
2	Cash-Patient Deposits	209,840		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (200,000))	2,828,896		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	785,615		6
7	Other Prepaid Expenses	27,318		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due Enrichment Foundation	(11,552)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,890,895	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,345		13
14	Buildings, at Historical Cost	3,542,209		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,322,802		16
17	Accumulated Depreciation (book methods)	(4,369,028)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	22,013		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,912)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify CIP)	3,948,065		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,516,494	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,407,389	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,974,539	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	217,659		28
29	Short-Term Notes Payable	4,133,393		29
30	Accrued Salaries Payable	831,828		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	161,160		32
33	Accrued Interest Payable	6,267		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Exp/ST Lease Pay/Due HFS	867,689		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,192,535	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	621,890		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)	\$ 621,890	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,814,425	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,592,964	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,407,389	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,976,476	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,976,476	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	616,488	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)	\$ 616,488	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)	\$ 4,592,964	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Childrens Habilitation Ctr

0018424

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,453,452	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,453,452	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	60,715	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 60,715	8
	C. Other Operating Revenue		
9	Payments for Education	3,035,660	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)	\$ 3,035,660	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,712	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,712	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	132,718	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 132,718	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,707,257	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,629,941	31
32	Health Care	9,308,786	32
33	General Administration	5,664,005	33
	B. Capital Expense		
34	Ownership	574,841	34
	C. Ancillary Expense		
35	Special Cost Centers	3,688,858	35
36	Provider Participation Fee	224,338	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,090,769	40
41	Income before Income Taxes (line 30 minus line 40)**	616,488	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 616,488	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 18,453,452.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		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)	\$ 18,453,452	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	1,816	2,080	\$ 142,232	\$ 68.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,120	32,887	1,719,362	52.28	3
4	Licensed Practical Nurses	20,991	23,811	882,922	37.08	4
5	CNAs & Orderlies	139,028	156,333	3,494,682	22.35	5
6	CNA Trainees					6
7	Licensed Therapist	22,643	26,623	1,214,853	45.63	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	17	17	319	18.76	10
11	Social Service Workers	7,156	7,973	285,927	35.86	11
12	Dietician	6,219	7,219	183,222	25.38	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,882	6,634	206,175	31.08	17
18	Housekeepers	14,199	16,957	377,862	22.28	18
19	Laundry	3,448	4,007	85,640	21.37	19
20	Administrator	1,928	2,120	180,758	85.26	20
21	Assistant Administrator					21
22	Other Administrative	1,880	2,120	195,259	92.10	22
23	Office Manager					23
24	Clerical	10,818	12,246	553,722	45.22	24
25	Vocational Instruction					25
26	Academic Instruction	15,273	17,925	548,865	30.62	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,808	2,123	66,152	31.16	31
32	Other Health Care(specify)					32
33	Other(specify) Nurse Practitioner	802	818	62,438	76.33	33
34	TOTAL (lines 1 - 33)	282,028	321,893	\$ 10,200,390 *	\$ 31.69	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	37,440	9-3	36
37	Medical Records Consultant				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				45
46	Other(specify) Dentist	Monthly	2,000	10-3	46
47	Physician	Monthly	21,350	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 60,790		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	214	\$ 15,970	10-3	50
51	Licensed Practical Nurses	8,587	486,464	10-3	51
52	Certified Nurse Assistants/Aides	18,612	690,697	10-3	52
53	TOTAL (lines 50 - 52)	27,413	\$ 1,193,131		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Theodore Schaetzle IV	CEO	0	\$ 195,259
Latonia Smith	Administrator	0	180,758
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 376,017
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
iSolved	Payroll	\$	65,372
Dave Stricklin	Non-Allowable		36,000
Matt Werner Consulting	Medicad Rate Consulting		36,000
Jeremy Brune & Associates	Accounting/Consulting		173,006
FGMK, LLC	Audit/Tax Consulting		217,567
Websensce Technologies	Website Technoloy		101,849
Duane Morris			417,645
Benesch Friedlander Copeland & Arnoff LLP			2,198
Greenberg Traurig			573,443
Lewis Brisbois Bisgaard & Smith LLP			41,736
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,664,816
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	136,458
Unemployment Compensation Insurance			116,445
FICA Taxes			751,621
Employee Health Insurance			481,250
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension/401K Match			96,394
Dental/Life Ins.			19,512
Uniforms			11,294
Education Allocation			(296,384)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,316,590
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			101,311
Health Care Worker Background Check (Indicate # of checks performed _____)			24,288
Patient Background Checks			
Association Dues (total from pg 22, #4)			9,547
Licenses and Fees			6,150
Subscriptions			1,789
Marketing			47,426
Less Education Allocation			(3,223)
Less: Public Relations Expense		(	
PAC and Lobbying payments			(1,824)
All non-allowable advertising			(47,426)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 138,038
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			12,668
Education Allocation			(1,221)
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	11,447

*** Attach copy of IMRF notifications**

****See instructions.**

Legal Detail

Date	Vendor	Service Description	Amount	ADJ	Allowable
45778	ACH	March legal fees	1,241.00		1,241.00
45778	ACH	March legal fees	657.50		657.50
45799	ACH	April legal fees	300.00		300.00
45708	DUANE MORRIS LLP (ACH)	January ISBE	6,429.24	(6,429.24)	-
45708	DUANE MORRIS LLP (ACH)	January healthcare regulatory	5,868.45		5,868.45
45708	DUANE MORRIS LLP (ACH)	January MFCU investigation	36,124.20		36,124.20
45740	DUANE MORRIS LLP (ACH)	January regulatory matters	3,373.65		3,373.65
45740	DUANE MORRIS LLP (ACH)	February ISBE	11,163.24	(11,163.24)	-
45758	DUANE MORRIS LLP (ACH)	March MFCU investigation	8,892.00		8,892.00
45758	DUANE MORRIS LLP (ACH)	March regulatory matters	3,888.00		3,888.00
45758	DUANE MORRIS LLP (ACH)	March Harvey ordinance	2,430.00	(2,430.00)	-
45758	DUANE MORRIS LLP (ACH)	March ISBE	6,321.24	(6,321.24)	-
45793	DUANE MORRIS LLP (ACH)	ISBE	1,613.25	(1,613.25)	-
45793	DUANE MORRIS LLP (ACH)	Regulatory matters	6,256.35		6,256.35
45793	DUANE MORRIS LLP (ACH)	MG	6,868.80	(6,868.80)	-
45825	DUANE MORRIS LLP (ACH)	May legal fees	2,591.10	(2,591.10)	-
45825	DUANE MORRIS LLP (ACH)	May legal fees	6,609.60		6,609.60
45825	DUANE MORRIS LLP (ACH)	May regulatory matters	583.20		583.20
45825	DUANE MORRIS LLP (ACH)	May ISBE	9,950.40	(9,950.40)	-
45847	DUANE MORRIS LLP (ACH)	Health care regulatory matters	1,683.45		1,683.45
45847	DUANE MORRIS LLP (ACH)	ISBE	17,312.60	(17,312.60)	-
45890	DUANE MORRIS LLP (ACH)	MG	2,028.60	(2,028.60)	-
45890	DUANE MORRIS LLP (ACH)	ISBE	2,962.80	(2,962.80)	-
45890	DUANE MORRIS LLP (ACH)	MFCU investigation	3,402.00		3,402.00
45890	DUANE MORRIS LLP (ACH)	Regulatory matters	6,785.10		6,785.10
45916	DUANE MORRIS LLP (ACH)	Regulatory matters	6,218.35		6,218.35
45916	DUANE MORRIS LLP (ACH)	ISBE	5,862.60	(5,862.60)	-
45916	DUANE MORRIS LLP (ACH)	MG	1,325.25	(1,325.25)	-
45940	DUANE MORRIS LLP (ACH)	SEPTEMBER legal fees	6,111.90	(6,111.90)	-
45940	DUANE MORRIS LLP (ACH)	SEPTEMBER regulatory matters	17,508.60		17,508.60
45940	DUANE MORRIS LLP (ACH)	ISBE	976.50	(976.50)	-
45971	DUANE MORRIS LLP (ACH)	October services	9,806.40		9,806.40
45971	DUANE MORRIS LLP (ACH)	October regulatory matters	5,235.30		5,235.30
45971	DUANE MORRIS LLP (ACH)	October ISBE	906.75	(906.75)	-
45999	DUANE MORRIS LLP (ACH)	November Regulatory matters	22,507.09		22,507.09
45999	DUANE MORRIS LLP (ACH)	November ISBE	5,548.05	(5,548.05)	-
45988	GREENBERG TRAURIG, LLP (ACH)	January CBA negotiations	11,135.63		11,135.63
45715	GREENBERG TRAURIG, LLP (ACH)	January Legal services	6,737.40		6,737.40
45715	GREENBERG TRAURIG, LLP (ACH)	January legal services	8,717.85		8,717.85
45715	GREENBERG TRAURIG, LLP (ACH)	January legal services	37,861.38	(37,861.38)	-
45733	GREENBERG TRAURIG, LLP (ACH)	FEBRUARY legal services	8,165.70		8,165.70
45733	GREENBERG TRAURIG, LLP (ACH)	CBA negotiations	14,011.20		14,011.20
45733	GREENBERG TRAURIG, LLP (ACH)	CBA negotiations	9,813.60		9,813.60
45733	GREENBERG TRAURIG, LLP (ACH)	FEBRUARY legal services	46,826.55	(46,826.55)	-
45733	GREENBERG TRAURIG, LLP (ACH)	FEBRUARY general employment matters	37,746.90		37,746.90
45754	GREENBERG TRAURIG, LLP (ACH)	CBA negotiations	11,244.15		11,244.15
45754	GREENBERG TRAURIG, LLP (ACH)	March CBA	10,152.00		10,152.00
45754	GREENBERG TRAURIG, LLP (ACH)	March legal services	38,990.70	(38,990.70)	-
45754	GREENBERG TRAURIG, LLP (ACH)	March general matters	18,954.00		18,954.00
45787	GREENBERG TRAURIG, LLP (ACH)	CBA	6,958.15		6,958.15
45787	GREENBERG TRAURIG, LLP (ACH)	CBA-APRIL	3,299.40		3,299.40
45787	GREENBERG TRAURIG, LLP (ACH)	APRIL Mason	5,188.88	(5,188.88)	-
45787	GREENBERG TRAURIG, LLP (ACH)	APRIL General matters	4,869.60		4,869.60
45812	GREENBERG TRAURIG, LLP (ACH)	CBA negotiations	1,261.90		1,261.90
45812	GREENBERG TRAURIG, LLP (ACH)	May general employment matters	5,059.05		5,059.05
45812	GREENBERG TRAURIG, LLP (ACH)	May services	241.65	(241.65)	-
45845	GREENBERG TRAURIG, LLP (ACH)	June Services	2,928.11		2,928.11
45845	GREENBERG TRAURIG, LLP (ACH)	JUNE CBA	2,284.20		2,284.20
45845	GREENBERG TRAURIG, LLP (ACH)	JUNE PN CBA	9,779.20		9,779.20
45845	GREENBERG TRAURIG, LLP (ACH)	JUNE	161.10	(161.10)	-
45870	GREENBERG TRAURIG, LLP (ACH)	Balance remaining on original invoice	1,110.00		1,110.00
45870	GREENBERG TRAURIG, LLP (ACH)	Expenses for March	1,833.67	(1,833.67)	-
45873	GREENBERG TRAURIG, LLP (ACH)	JULY General employment matters	28,748.15		28,748.15
45873	GREENBERG TRAURIG, LLP (ACH)	JULY CBA	16,375.95		16,375.95
45873	GREENBERG TRAURIG, LLP (ACH)	JULY	332.55		332.55
45915	GREENBERG TRAURIG, LLP (ACH)	AUGUST GENERAL MATTERS	16,519.17		16,519.17
45915	GREENBERG TRAURIG, LLP (ACH)	AUGUST CBA	33,930.00		33,930.00
45937	GREENBERG TRAURIG, LLP (ACH)	SEPTEMBER GENERAL MATTERS	19,238.85		19,238.85
45937	GREENBERG TRAURIG, LLP (ACH)	SEPTEMBER CBA NEGOTIATIONS	31,107.60		31,107.60
45937	GREENBERG TRAURIG, LLP (ACH)	SEPTEMBER CBA NEGOTIATIONS	8,381.90		8,381.90
45968	GREENBERG TRAURIG, LLP (ACH)	October CBA service	2,707.20		2,707.20
45968	GREENBERG TRAURIG, LLP (ACH)	October services	22,962.76		22,962.76
45968	GREENBERG TRAURIG, LLP (ACH)	October CBA services	34,200.00		34,200.00
45984	GREENBERG TRAURIG, LLP (ACH)	November CBA services	6,229.26		6,229.26
45984	GREENBERG TRAURIG, LLP (ACH)	November services	26,999.12		26,999.12
45809	LEWIS BRISBOIS BISGAARD & SMITH LLP	April legal fees	7,190.00	(7,190.00)	-
45838	LEWIS BRISBOIS BISGAARD & SMITH LLP	May legal fees	4,423.00	(4,423.00)	-
45868	LEWIS BRISBOIS BISGAARD & SMITH LLP	JUNE legal fees	4,656.50	(4,656.50)	-
45908	LEWIS BRISBOIS BISGAARD & SMITH LLP	August legal fees	3,252.70	(3,252.70)	-
45937	LEWIS BRISBOIS BISGAARD & SMITH LLP	SEPTEMBER LEGAL FEES	4,564.36	(4,564.36)	-
45969	LEWIS BRISBOIS BISGAARD & SMITH LLP	October services	5,809.50	(5,809.50)	-
46006	LEWIS BRISBOIS BISGAARD & SMITH LLP	Court filing	462.50	(462.50)	-
46022	DUANE MORRIS LLP	Accrued Expense (Duane Morris)	53,888.50		53,888.50
46022	DUANE MORRIS LLP	Accrued Expense (Lewis, Brisois)	11,377.23	(11,377.23)	-
46022	Journal Entry	Accrued Expense (Greenberg Traurig)	20,358.94		20,358.94
46022	Journal Entry	Legal Expense Redclass	20,347.81	(20,347.81)	-
46022	Journal Entry	Legal Expense Redclass	12,322.50	(12,322.50)	-
46022	Journal Entry	Contingency Reserve - Legal	95,941.77	(95,941.77)	-
Totals			1,035,922.29	(391,854.06)	643,168.23

Children's Habilitation Center
0018424
Seminar Schedule
1/1/2025-12/31/2025

Date	Name	Description	Amount
01/07/2025	BAUGH, SYLVESTER	1-6-25 Orientation	185.00
01/17/2025	NEW SHINING LIGHT Monthly	Community days 1-13-25	125.00
01/21/2025	BAUGH, SYLVESTER	Orientation 1/21/25	185.00
02/04/2025	BAUGH, SYLVESTER	2/3/25	185.00
02/17/2025	BAUGH, SYLVESTER	2/17/25	185.00
03/04/2025	BAUGH, SYLVESTER	Orientation 3/3/25	185.00
03/18/2025	BAUGH, SYLVESTER	Orientation 3/17/25	185.00
04/01/2025	BAUGH, SYLVESTER	3/31/25 orientation	185.00
04/07/2025	NEW SHINING LIGHT Monthly	COMMUNITY DAY	125.00
04/15/2025	BAUGH, SYLVESTER	4-14-25 Orientation	185.00
04/28/2025	BAUGH, SYLVESTER	4/28/25 orientation	185.00
05/12/2025	BAUGH, SYLVESTER	Orientation	185.00
05/27/2025	BAUGH, SYLVESTER	orientation 5/27/25	185.00
06/09/2025	BAUGH, SYLVESTER	Orientation	185.00
06/23/2025	BAUGH, SYLVESTER	Orientation	185.00
07/07/2025	BAUGH, SYLVESTER	7-7-25 Orientation	185.00
07/21/2025	BAUGH, SYLVESTER	Orientation	185.00
07/28/2025	ABDUL-MATIN SMITH	Community Days photography	120.00
08/04/2025	BAUGH, SYLVESTER	Orientation	185.00
08/18/2025	BAUGH, SYLVESTER	Orientation	185.00
09/02/2025	BAUGH, SYLVESTER	Orientation	185.00
09/15/2025	BAUGH, SYLVESTER	Orientation	185.00
09/29/2025	BAUGH, SYLVESTER	Orientation	185.00
10/15/2025	BAUGH, SYLVESTER	Orientation	185.00
10/27/2025	BAUGH, SYLVESTER	Orientation	185.00
11/10/2025	BAUGH, SYLVESTER	Orientation	185.00
11/24/2025	BAUGH, SYLVESTER	Orientation	185.00
12/08/2025	BAUGH, SYLVESTER	Orientation	185.00
12/22/2025	BAUGH, SYLVESTER	Orientation	185.00
12/31/2025		CC Transaction Allocation - YTD 12/31/25	5,733.09
08/28/2025	LIVING LIFE LONGER LTD	CPR class	360.00
08/29/2025	LIVING LIFE LONGER LTD	CPR class	270.00
10/07/2025	LIVING LIFE LONGER LTD	BLS renewal	180.00
10/09/2025	LIVING LIFE LONGER LTD	BLS renewal	270.00
07/24/2025	MARKLUND DAY SCHOOL	Professional development class for Education dept	675.00
	EDUCATION ALLOCATION		-1,221.00
Total			11,447.09

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 |
|--|---------------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>3,973</u> |
| <u>Other, please specify <u>Pediatric Association</u></u> | <u>3,750</u> |
| | <u>7,723</u> 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.
- | | |
|--|---------------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,824</u> |
| <u>Other, please specify <u>Pediatric Association</u></u> | |
| | <u>1,824</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|---------------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>5,797</u> |
| <u>Other, please specify <u>Pediatric Association</u></u> | <u>3,750</u> |
| | <u>9,547</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 79,558 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. \$ 224,338
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? N/A 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? LN 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: FGMK, LLC
- (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.