

		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: 0008201

Facility Name: DuPage Care Center

Address: 400 N County Farm Rd Wheaton 60187

NumberCityZip Code

County: DuPage

Telephone Number: 630-665-6400 Fax # 630-784-4203

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1935

Type of Ownership:

☐

VOLUNTARY, NON-PROFIT

☐

Charitable Corp.

☐

Trust

IRS Exemption Code

☐

PROPRIETARY

☐

Individual

☐

Partnership

☐

Corporation

☐

"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: Matthew LarshTelephone Number: 630-368-3666Email 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 12/1/24 to 11/30/25 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) Janelle Chadwick

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title) Matthew LarshSigning Director

(Firm Name & Address) CLA - CliftonLarsonAllen833 West Lincoln Highway, Sute 210W, Schererville, IN 4637

(Telephone) 630-368-3666Fax # 219-864-0055

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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/24 Ending: 11/30/25

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>366</u>	Skilled (SNF)	<u>366</u>	<u>133,590</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>366</u>	TOTALS	<u>366</u>	<u>133,590</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	14,235	41,513	6,376	31	6,162	2,753	1,596	72,666	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	14,235	41,513	6,376	31	6,162	2,753	1,596	72,666	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 54.39%

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)

Employee meals, Employee Pharmacy, Therapy, County Laundry

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 1/1/1938

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 366

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 11/30/2025 Fiscal Year: 11/30/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/24 Ending: 11/30/25
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	1,785,323	102,522	17,438	1,905,283		1,905,283		1,905,283			1
2	Food Purchase		987,345		987,345		987,345	(870,394)	116,951			2
3	Housekeeping	1,304,895	179,042	56,631	1,540,568		1,540,568	(27,689)	1,512,879			3
4	Laundry	444,193	94,532	10,495	549,220		549,220		549,220			4
5	Heat and Other Utilities			1,019,901	1,019,901		1,019,901	1,875,753	2,895,654			5
6	Maintenance			210,406	210,406		210,406	149,766	360,172			6
7	Other (specify):*											7
8	TOTAL General Services	3,534,411	1,363,441	1,314,871	6,212,723		6,212,723	1,127,436	7,340,159			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,954,130	378,927	758,643	13,091,700		13,091,700		13,091,700			10
10a	Therapy	561,108	16,722	430,264	1,008,094	(173,875)	834,219		834,219			10a
11	Activities	506,814	6,846	719	514,379		514,379		514,379			11
12	Social Services	818,755	8,769	7,397	834,921		834,921		834,921			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	13,840,807	411,264	1,197,023	15,449,094	(173,875)	15,275,219		15,275,219			16
	C. General Administration											
17	Administrative	862,074	109,532	317,782	1,289,388		1,289,388	1,087,995	2,377,383			17
18	Directors Fees											18
19	Professional Services			241,878	241,878		241,878		241,878			19
20	Dues, Fees, Subscriptions & Promotions			61,319	61,319		61,319		61,319			20
21	Clerical & General Office Expenses	578,418	162,558	(20,273)	720,703		720,703		720,703			21
22	Employee Benefits & Payroll Taxes			7,004,481	7,004,481		7,004,481	254,521	7,259,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,507	22,507		22,507		22,507			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							268,384	268,384			26
27	Other (specify):*											27
28	TOTAL General Administration	1,440,492	272,090	7,627,694	9,340,276		9,340,276	1,610,900	10,951,176			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	18,815,710	2,046,795	10,139,588	31,002,093	(173,875)	30,828,218	2,738,336	33,566,554			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			1,684,143	1,684,143		1,684,143	(660,555)	1,023,588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			145,218	145,218		145,218		145,218			35
36	Other (specify):*											36
37	TOTAL Ownership			1,829,361	1,829,361		1,829,361	(660,555)	1,168,806			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	953,007	1,500,434	625,112	3,078,553	173,875	3,252,428	(19,745)	3,232,683			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			444,542	444,542		444,542		444,542			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	953,007	1,500,434	1,069,654	3,523,095	173,875	3,696,970	(19,745)	3,677,225			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	19,768,717	3,547,229	13,038,603	36,354,549		36,354,549	2,058,036	38,412,585			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	(660,555)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	2,718,591			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 2,058,036		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,058,036		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	Medicare Part B Therapy	X		173,875	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 173,875		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Marketing - Administration	(2,871)	17	3
4	Cafeteria Income	(870,394)	2	4
5	Campus Cleaning Svc Income	(27,689)	3	5
6	Misc Revenue	(7,303)	17	6
7	Refunds & Overpayments	(12,401)	17	7
8	Wellness Center Income	(19,745)	39	8
9	Service Fee Income	(2,135)	17	9
10				10
11	DuPage County Cost Alloc - Heating/Utilities	1,875,753	5	11
12	DuPage County Cost Alloc - Equip Repair/Maint	149,766	6	12
13	DuPage County Cost Alloc - Administration	1,112,705	17	13
14	DuPage County Cost Alloc - Employee Benefits	254,521	22	14
15	DuPage County Cost Alloc - Prof. Liability Ins.	268,384	26	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	2,718,591		49

Summary A

11/30/25

[illegible]

Summary B

11/30/25

[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
DuPage County	100			None		
(DuPage Care Center is a						
subunit of DuPage County. See Sch. VIII						
for the allocation of costs from the						
county.)						

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		N/A	\$	N/A		\$	\$	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		N/A	\$			\$	\$	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	N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								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	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/24 Ending: 11/30/25

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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.			\$		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.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		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.			\$		7
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 258,737 B. General Construction Type: Exterior Masonry Rough Concl Frame Steel Number of Stories 5

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

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

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

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? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Nursing Home Bldgs	400,000	1947	\$ 784,360	1
2					2
3	TOTALS	400,000		\$ 784,360	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104		1978	1978	\$ 4,456,548	\$	30	\$	\$	\$	4
5	148		1947	1947	70,858		5				5
6	16		1979	1979	1,750,524		30				6
7			1964	1983	1,172,064		34				7
8	100		1993	1993	6,516,821		Various	76,406	76,406		8
	Improvement Type**										
9	1976 IMPROVEMENTS			1976	44,372		VARIOUS				9
10	1977 IMPROVEMENTS			1977	8,545		VARIOUS				10
11	1978 IMPROVEMENTS			1978	12,188		VARIOUS				11
12	1979 IMPROVEMENTS			1979	844		VARIOUS				12
13	1981 IMPROVEMENTS			1981	212,304		VARIOUS				13
14	1983 IMPROVEMENTS			1983	4,134,469		VARIOUS				14
15	1985 IMPROVEMENTS			1985	91,792		VARIOUS				15
16	1990 IMPROVEMENTS			1990	205,306		VARIOUS				16
17	1991 IMPROVEMENTS			1991	331,513		VARIOUS				17
18	1992 IMPROVEMENTS			1992	604,208		VARIOUS				18
19	1993 IMPROVEMENTS			1993	642,712		VARIOUS				19
20	1994 IMPROVEMENTS			1994	105,577		VARIOUS				20
21	1995 IMPROVEMENTS			1995	35,064		VARIOUS				21
22	1996 IMPROVEMENTS			1996	43,556		VARIOUS				22
23	1997 IMPROVEMENTS			1997	320,587		VARIOUS				23
24	1998 IMPROVEMENTS			1998	10,922		VARIOUS				24
25	1999 IMPROVEMENTS			1999	701,043		VARIOUS				25
26	2000 IMPROVEMENTS			2000	832,461		VARIOUS				26
27	2001 IMPROVEMENTS			2001	473,208		VARIOUS				27
28	2002 IMPROVEMENTS			2002	1,911,073		VARIOUS				28
29	2003 IMPROVEMENTS			2003	376,034		VARIOUS	872	872		29
30	2004 IMPROVEMENTS			2004	165,176		VARIOUS				30
31	2005 IMPROVEMENTS			2005	159,736		VARIOUS				31
32	2006 IMPROVEMENTS			2006	2,638,576		VARIOUS	68,027	68,027		32
33	2009 IMPROVEMENTS			2009	626,745		VARIOUS	262	262		33
34	2010 IMPROVEMENTS			2010	1,262,723		VARIOUS	59,669	59,669		34
35	2011 IMPROVEMENTS			2011	404,693		VARIOUS				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 DuPage Care Center

0008201

Report Period Beginning:

12/1/24

Ending:

11/30/25

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	2012 IMPROVEMENTS	2012	\$ 390,730	\$	VARIOUS	\$	\$	\$	37
38	2013 IMPROVEMENTS	2013	277,415		VARIOUS				38
39	2014 IMPROVEMENTS	2014	120,163		VARIOUS				39
40	2015 IMPROVEMENTS	2015	6,735,981		VARIOUS	332,958	332,958		40
41	2016 IMPROVEMENTS	2016	32,751		VARIOUS	2,305	2,305		41
42	KennethMoy DuPage Care CtrSign	2017	3,240		5				42
43	Outdoor Education Project	2017	46,144		10	4,614	4,614		43
44	Roof Repair & Replacement	2017	182,500		10	18,250	18,250		44
45	S & E Wing Window Replacements	2017	664,110		10	66,411	66,411		45
46	Entrance Awnings & Awning Walls	2018	5,200		5	433	433		46
47	Roof Repair/Restoration	2018	164,716		10	16,472	16,472		47
48	Fencing for Garden Courtyard	2018	11,628		5				48
49	Roof Restoration	2018	18,275		5				49
50	Resurface and Stripe Care Center Parking Lot	2018	18,180		5				50
51	Electrical Infrastructure Pro	2021	301,833		20	15,092	15,092		51
52	- updating power panel in Kitchen on first floor CC								52
53	- updating of electrical system in care center, labor and materials								53
54	- replacement of medium voltage and low voltage electrical distribution equipment								54
55	Domestic Water Heater - Power Plant for Care Center	2023	116,857		10	11,686	11,686		55
56	Care Center Dumpster Tipper Pad replacement	2023	14,445		5	2,889	2,889		56
57	Replacement of Air Handling Units S-3, S-4, S-5	2023	65,357		15	4,357	4,357		57
58	Care Center Window Replacement Project	2023	898,657		15	59,910	59,910		58
59	- Solarium - ALL								59
60	- Ground Floor: Admin Hall est/west side, Pharmacy, Wellness Center,								60
61	Stairwell G 1, 2, 3 Floors, Admissions								61
62	- 1st Floor South: South vacant 1st Floor east/west side, South Chaple & Rec room								62
63	- 3rd Floor South: medical records westide, Finance south side, Nursing north side								63
64	Wander guard addition	2023	4,350			435	435		64
65	Cameras for center patio	2023	7,087			1,417	1,417		65
66	Camera for second floor incline floor ramps	2023	3,065			613	613		66
67	Camera for second floor incline floor ramps	2023	3,065			613	613		67
68	6 Cameras and installation for garden (east/west)	2023	18,208			3,642	3,642		68
69	4N Construction and Renovation (see detailed listing attached)	2024	1,783,899		18	99,106	99,106		69
70	TOTAL (lines 4 thru 69)		\$ 42,210,098	\$		\$ 846,439	\$ 846,439	\$	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 42,210,098	\$		\$ 846,439	\$ 846,439	\$	1
2	FY2025 Additions								2
3									3
4	Air Handling Units Replacement	2025	3,347,741						4
5	Replacement of Convactor	2025	277,829						5
6	3Center,3South,Ground Floor Lo	2025	8,107,084						6
7	HVAC Improvements	2025	203,930						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	Depreciation Expense per books			1,506,994			(1,506,994)		18
19								32,888,851	19
20	Accumulated Depreciation per books								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	TOTAL (lines 1 thru 33)		\$ 54,146,681	\$ 1,506,994		\$ 846,439	\$ (660,555)	\$ 32,888,851	34

**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	\$ 986,072	\$ 149,498	\$ 149,498	\$		\$ 470,357	71
72	Current Year Purchases	339,094	6,624	6,624			12,835	72
73	Fully Depreciated Assets	2,393,046						73
74								74
75	TOTALS	\$ 3,718,212	\$ 156,122	\$ 156,122	\$		\$ 483,192	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	Maint and Transport	2011 Extended Length Van		\$ 31,300	\$	\$	\$		\$ 31,300	76
77	Transport	2023 Ford Transit Wheelchair va	2023	88,300	8,830	8,830		10	10,633	77
78	Transport	2023 Ford Transit Wheelchair va	2023	88,300	8,830	8,830		10	10,633	78
79		2024 F550 BUS	2025	202,044	3,367	3,367		10	6,735	79
80	TOTALS			\$ 409,944	\$ 21,027	\$ 21,027	\$		\$ 59,301	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)	\$ 59,059,197	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,684,143	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,023,588	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (660,555)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 33,431,344	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	CIP	\$ 6,097,056	92
93			93
94			94
95		\$ 6,097,056	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 N/A
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: \$ 145,218 Description: See attached equipment rental listing
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				1,328,337		1,328,337	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Medical/Dental/Lab</u>	39-2					406,763		406,763	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$	\$ 1,735,100		\$ 1,735,100	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	\$ 25,810,864	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,304,200)	5,087,309		3
4	Supply Inventory (priced at cost)	387,483		4
5	Short-Term Investments	1,336,356		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	41,940		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	141,072		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 32,805,024	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	64,622,332		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,944,892		16
17	Accumulated Depreciation (book methods)	(38,832,892)		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): CIP	6,097,056		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,615,748	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 69,420,772	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,027,056	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,048,563		30
31	Accrued Taxes Payable (excluding real estate taxes)	173,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	45,393		35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	(8,650,827)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (6,355,979)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other Long-Term	1,992,182		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,992,182	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (4,363,797)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,784,569	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 69,420,772	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 67,388,170	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 67,388,170	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,428,046)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	8,906,794	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) Prior Period Adjustment	3,917,651	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 6,396,399	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)	\$ 73,784,569	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DuPage Care Center

0008201

Report Period Beginning: 12/1/24

Ending:

11/30/25

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	\$ 29,043,321	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 29,043,321	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	870,394	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,561,869	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	21,821	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,454,084	23
	D. Non-Operating Revenue		
24	Contributions	456,888	24
25	Interest and Other Investment Income***	953,150	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,410,038	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	680,189	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 680,189	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 33,587,632	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	6,212,723	31
32	Health Care	15,449,094	32
33	General Administration	9,340,276	33
	B. Capital Expense		
34	Ownership	1,829,361	34
	C. Ancillary Expense		
35	Special Cost Centers	3,078,553	35
36	Provider Participation Fee	444,542	36
	D. Other Expenses (specify):		
37	<u>Indirect Expenses</u>	3,661,129	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 40,015,678	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,428,046)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,428,046)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 5,891,423.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	17,180,937.00	45
46	MMAI-Medicaid is the Primary Payer	2,638,828.00	46
47	MMAI-Medicare is the Primary Payer	21,165.00	47
48	Private Pay	1,245,641.00	48
49	Medicare Part A	1,879,566.00	49
50	Other-(specify)	185,761.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 29,043,321	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	1,411	1,868	\$ 143,906	\$ 77.04	1
2	Assistant Director of Nursing	4,621	5,573	286,766	51.46	2
3	Registered Nurses	76,402	131,542	4,386,113	33.34	3
4	Licensed Practical Nurses	29,070	54,328	1,274,475	23.46	4
5	CNAs & Orderlies	158,351	292,170	5,022,003	17.19	5
6	CNA Trainees					6
7	Licensed Therapist	3,366	3,970	209,904	52.87	7
8	Rehab/Therapy Aides	11,888	13,984	354,943	25.38	8
9	Activity Director	1,541	1,878	85,726	45.65	9
10	Activity Assistants	15,334	19,165	444,223	23.18	10
11	Social Service Workers	11,328	13,624	450,425	33.06	11
12	Dietician	6,120	7,109	204,961	28.83	12
13	Food Service Supervisor	5,236	7,071	309,313	43.74	13
14	Head Cook	9,100	13,090	256,736	19.61	14
15	Cook Helpers/Assistants	54,440	59,902	1,062,720	17.74	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	58,861	69,908	1,305,754	18.68	18
19	Laundry	21,594	25,240	439,555	17.42	19
20	Administrator	1,544	1,939	199,204	102.74	20
21	Assistant Administrator	3,297	4,102	280,949	68.49	21
22	Other Administrative	30,955	45,640	1,022,615	22.41	22
23	Office Manager					23
24	Clerical	15,083	18,739	605,559	32.32	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	3,226	3,705	82,275	22.21	31
32	Other Health C: Café	28,681	34,324	974,573	28.39	32
33	Other(specify) <u>Volunteers</u>	12,073	13,586	366,019	26.94	33
34	TOTAL (lines 1 - 33)	563,522	842,457	\$ 19,768,717 *	\$ 23.47	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		48,000	10-3	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16,579	661,279	10-3	52
53	TOTAL (lines 50 - 52)	16,579	\$ 661,279		53

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

** 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 |
|--|---------------------|
| <u>LEADING AGE</u> | <u>32,400</u> |
| <u>Other, please specify IL Aging Services Network</u> | <u>17,537</u> |
| | <u>49,937</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>LEADING AGE</u> | |
| <u>Other, please specify IL Aging Services Network</u> | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|---------------------|
| <u>LEADING AGE</u> | <u>32,400</u> |
| <u>Other, please specify IL Aging Services Network</u> | <u>17,537</u> |
| | <u>49,937</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 294,518 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. \$ 444,542
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ (870,394)
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? 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?
- 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: Baker Tilly
- (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.