

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Rd Glen Carbon 62034
Number City Zip Code

County: Madison

Telephone Number: (618) 288-5014 Fax #: (618) 288-0206

HFS ID Number:

Date of Initial License for Current Owners: 05/14/1979

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT

☒ Charitable Corp.

☐ Trust

IRS Exemption Code 501(c)(3)

☐ 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: Cindy A. Tefteller
Telephone Number: (618) 465-7717
Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)

(Print Name and Title) Cindy A. Tefteller CPA

(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 E Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax #: (618) 465-7710

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

Eden Village Care Center

#

0023382

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	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	107	TOTALS	107	39,055	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	2,615	2,853	479		9,870	1,308	1,386	18,511	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,615	2,853	479		9,870	1,308	1,386	18,511	14

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

47.40%

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)

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

X

NO

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

YES

X

NO

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

Date started

05/14/1979

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

YES

X

Date

05/14/1979

NO

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

107

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary			731,933	731,933		731,933	(35,291)	696,642			1
2	Food Purchase											2
3	Housekeeping	104,275	12,787		117,062		117,062		117,062			3
4	Laundry	104,275	12,787		117,062		117,062		117,062			4
5	Heat and Other Utilities			379,874	379,874		379,874		379,874			5
6	Maintenance	184,458	5,579	309,898	499,935		499,935	(10,909)	489,026			6
7	Other (specify):*											7
8	TOTAL General Services	393,008	31,153	1,421,705	1,845,866		1,845,866	(46,200)	1,799,666			8
	B. Health Care and Programs											
9	Medical Director			20,800	20,800		20,800		20,800			9
10	Nursing and Medical Records	2,759,698	130,214	9,856	2,899,768		2,899,768		2,899,768			10
10a	Therapy											10a
11	Activities	55,436	2,036	4,742	62,214		62,214		62,214			11
12	Social Services	40,820		1,719	42,539		42,539		42,539			12
13	CNA Training											13
14	Program Transportation		984	1,487	2,471		2,471		2,471			14
15	Other (specify):* Seniors N Motion	2,867			2,867		2,867	(2,867)				15
16	TOTAL Health Care and Programs	2,858,821	133,234	38,604	3,030,659		3,030,659	(2,867)	3,027,792			16
	C. General Administration											
17	Administrative	76,345		58,712	135,057		135,057	(58,403)	76,654			17
18	Directors Fees											18
19	Professional Services			15,609	15,609		15,609		15,609			19
20	Dues, Fees, Subscriptions & Promotions			26,413	26,413		26,413	(11,735)	14,678			20
21	Clerical & General Office Expenses	170,818	3,228	125,337	299,383		299,383		299,383			21
22	Employee Benefits & Payroll Taxes			558,335	558,335		558,335		558,335			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,130	4,130		4,130		4,130			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			251,905	251,905		251,905		251,905			26
27	Other (specify):*											27
28	TOTAL General Administration	247,163	3,228	1,040,441	1,290,832		1,290,832	(70,138)	1,220,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,498,992	167,615	2,500,750	6,167,357		6,167,357	(119,205)	6,048,152			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

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			191,163	191,163		191,163	(8,312)	182,851			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,468	17,468		17,468	(8,544)	8,924			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			208,631	208,631		208,631	(16,856)	191,775			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,970	309,094	362,064		362,064		362,064			39
40	Barber and Beauty Shops	9,469	687		10,156		10,156		10,156			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,933	318,933		318,933		318,933			42
43	Other (specify):* A/L RC		35,458	4,220,220	4,255,678		4,255,678		4,255,678			43
44	TOTAL Special Cost Centers	9,469	89,115	4,848,247	4,946,831		4,946,831		4,946,831			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,508,461	256,730	7,557,628	11,322,819		11,322,819	(136,061)	11,186,758			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	(2,867)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(35,291)	1		4
5	Telephone, TV & Radio in Resident Rooms	(10,909)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,312)	30		9
10	Interest and Other Investment Income	(8,544)	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	(58,403)	17		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	(9,813)	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	(1,922)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,061)		\$	30

BHF USE ONLY							
48		49		50		51	

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))	\$ (136,061)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (2,585)	20	1
2	Other Expenses Related to Lobbying Activities	663	20	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
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25				25
26				26
27				27
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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	(1,922)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing for members of the Board of Directors						

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

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		Section 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

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		Section 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	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								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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

Fax Number**SEE ACCOUNTANTS' PREPARATION REPORT**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	FCB Bank		X	Line of Credit				247,128				6,118	6
7	Miscellaneous		X	Vendor Interest								11,350	7
8													8
9	TOTAL Facility Related						\$	247,128			\$	17,468	9
	B. Non-Facility Related*												
10	Interest Income Offset											(8,544)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(8,544)	14
15	TOTALS (line 9+line14)						\$	247,128			\$	8,924	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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	19,889,410	8		
Real Estate Tax Bill for Calendar Year:	2020	395,427	9		
	2021	406,168	10		
	2022	420,670	11		
	2023	444,882	12		
	2024	103,222	13		
Real Estate Taxes are for the Assisted Living and Independent Living facilities and are reported on line 43 in the current year.					
				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.

FACILITY NAME	Eden Village Care Center	COUNTY	Madison
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CONTACT PERSON REGARDING THIS REPORT Sara McMahan

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,924 B. General Construction Type: Exterior Brick Frame Steel 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. [] (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).
Eden Retirement Center, Independent Living Facility (82 apartments; 40 duplex units)
Eden Retirement Center, Assisted Living (74 Units)

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 [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	Land - SNF		1979	\$ 166,295	1
2					2
3	TOTALS			\$ 166,295	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	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	107		1979	1979	\$ 2,008,520	\$	30	\$	\$	\$ 2,008,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Fixed Assets		1979		63,646		Various			63,646	9
10	1985 Fixed Assets		1985		28,768		Various			28,768	10
11	1989 Fixed Assets		1989		21,453		Various			21,453	11
12	1990 Fixed Assets		1990		34,575		Various			34,575	12
13	1991 Fixed Assets		1991		20,835		Various			20,835	13
14	1992 Fixed Assets		1992		106,730		Various			106,730	14
15	1993 Fixed Assets		1993		68,267		Various			68,267	15
16	1994 Fixed Assets		1994		42,035		Various			42,035	16
17	1995 Fixed Assets		1995		90,923		Various			90,923	17
18	1996 Fixed Assets		1996		64,116		Various			64,116	18
19	1997 Fixed Assets		1997		6,000		Various			6,000	19
20	1998 Fixed Assets		1998		1,632,945	39,650	Various	39,650		1,197,851	20
21	1999 Fixed Assets		1999		620,363	12,650	Various	12,650		450,872	21
22	2000 Fixed Assets		2000		31,137	275	Various	275		27,219	22
23	2001 Fixed Assets		2001		59,749		Various			59,749	23
24	2002 Fixed Assets		2002		9,200	368	Various	368		8,506	24
25	2003 Fixed Assets		2003		9,961	150	Various	150		9,652	25
26	2004 Fixed Assets		2004		23,265	599	Various	599		20,920	26
27	2005 Fixed Assets		2005		178,706	1,134	Various	1,134		173,534	27
28	2006 Fixed Assets		2006		119,533	4,146	Various	4,146		118,151	28
29	2007 Fixed Assets		2007		90,478		Various			90,478	29
30	2008 Fixed Assets		2008		47,724	361	Various	361		46,727	30
31	2010 Fixed Assets		2010		2,349		Various			2,349	31
32	2011 Fixed Assets		2011		34,912		Various			34,912	32
33	2012 Fixed Assets		2012		151,427	6,000	Various	6,000		69,328	33
34	2013 Fixed Assets		2013		236,391	6,760	Various	6,760		149,370	34
35	Wander Guard		2015		12,000	800	20	800		8,334	35
36	Wander Guard		2015		11,880	878	10	878		9,280	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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof	2015	\$ 21,667	\$ 1,083	20	\$ 1,083	\$	\$ 11,195	37
38	Roof	2015	21,667	1,083	20	1,083		11,104	38
39	Roof	2015	21,667	1,083	20	1,083		11,104	39
40	Wander Guard	2015	4,605	346	10	346		4,605	40
41	Roof	2015	1,900	95	20	95		958	41
42	Wander Guard	2015	4,089	113	10	113		3,852	42
43	Condensing Unit	2016	4,489	449	10	449		4,414	43
44	Wander Guard	2016	7,791	779	10	779		7,531	44
45	Wander Guard	2016	4,089	409	10	409		4,054	45
46	FIN 47 Asset		20,377		12			20,377	46
47	Flooring - DON Office	2019	1,191		5			1,191	47
48	Flooring - Kitchen & Purchasing Offices	2019	2,457		5			2,457	48
49	Flooring - Administrator/Marketing Offices & Reception Area	2019	2,988		5			2,988	49
50	Hardwood Flooring - Therapy Hallway and CFO Office	2019	4,162		10			4,162	50
51	Concrete - Parking Lots, Sidewalk, & Curbing	2019	51,700	5,170	20	5,170		32,313	51
52	Roof	2020	8,600		2			8,600	52
53	CAT5e Cable	2020	2,560	128	5	128		2,560	53
54	Water Heater, Waterline - Therapy Room	2020	7,369	737	10	737		3,922	54
55	A/C Unit, Fan Vent - Kitchen	2020	3,050	536	5	536		3,050	55
56	Sprinkler System Air Compressor Pump - Therapy Room	2020	5,856	740	5	740		4,766	56
57	Flooring - Social Services & Admissions Office	2020	1,523	224	5	224		1,523	57
58	Water Heater - Care Center	2020	9,440	849	10	849		6,044	58
59	PTAC for 6 Care Center Rooms	2020	3,978	464	5	464		3,978	59
60	Furnance for Pump for Therapy Room	2020	6,956	1,180	5	1,180		6,956	60
61	Zultys Phone System	2020	120,111	12,011	10	12,011		71,066	61
62	Employee Lounge Air Handler	2021	4,300	430	10	430		2,186	62
63	Water Heater Installment - Hall 1	2021	9,000	900	10	900		4,575	63
64	Water Line Replacement - Hall 4	2021	4,749	475	10	475		2,335	64
65	Valve Replacement - Basement	2021	2,775	555	5	555		2,359	65
66	Grease Trap	2022	4,400	440	10	440		1,760	66
67	Fire Panel Upgrade	2022	38,518	3,852	10	3,852		14,036	67
68	Heat Exchanger - West Admin Building	2022	3,922	784	5	784		3,072	68
69	Paint, Tile, Sink, Hand Dryer - Admin Hallway Bathroom	2022	9,551	914	10	914		3,528	69
70	TOTAL (lines 4 thru 69)		\$ 6,249,385	\$ 109,600		\$ 109,600	\$	\$ 5,301,721	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1 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		\$ 6,249,385	\$ 109,600		\$ 109,600	\$	\$ 5,301,721	1
2	Actuator Replacement	2022	5,140	514	10	514		1,970	2
3	Hall 3 PTAC	2023	7,527	1,505	5	1,505		4,516	3
4	300 Hall PTAC	2023	4,735	947	5	947		2,762	4
5	Laundry HVAC	2023	4,958	992	5	992		2,644	5
6	Water Heater	2023	12,270	1,227	10	1,227		2,761	6
7	Therapy Room Fountain & Flooring	2023	5,281	922	10	922		2,481	7
8	Flooring CC301	2024	2,214	221	10	221		351	8
9	3 Annunciators for Fire Panel	2024	15,303	3,061	5	3,061		4,336	9
10	Flooring #506, 102, & 108	2024	3,257	651	5	651		797	10
11	Flooring 100 Hall	2024	2,460	492	5	492		575	11
12	Flooring 300 Hall	2024	4,577	915	5	915		992	12
13	Flooring Room 510, 604, & 304	2024	5,448	136	40	136		241	13
14	Sparlin Plumbing - Water Heater	2024	18,478	1,848	10	1,848		3,542	14
15	Handrails in Hall 100	2025	7,026	541	10	541		541	15
16	3 Doors 100 Hall and Closet Doors 300 Hall	2025	3,954	389	5	389		389	16
17	Flooring Room 108, 404, & 405	2025	3,307	457	5	457		457	17
18	Wallpaper and Hanging Wallpaper - Hall 100 & 300	2025	4,354	230	10	230		230	18
19	Flooring - CC Dining Room & 104 - Hall 300 Cove Base	2025	3,001	171	10	171		171	19
20	Wall Panels - 300 Hall & 406CC	2025	2,905	154	3	154		154	20
21	Flooring Room 302, 307, & 309	2025	3,578	60	5	60		60	21
22	Kickrail - CC	2025	4,659	39	10	39		39	22
23	PTAC Units	2025	3,594	419	5	419		419	23
24									24
25									25
26									26
27									27
28									28
29									29
30	A/L & Loft Assets			8,312			(8,312)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,377,411	\$ 133,803		\$ 125,491	\$ (8,312)	\$ 5,332,149	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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 12B, Carried Forward		\$6,377,411	\$133,803		\$125,491	\$ (8,312)	\$5,332,149	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$6,377,411	\$133,803		\$125,491	\$ (8,312)	\$5,332,149	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 613,240	\$ 37,189	\$ 37,189	\$		\$ 534,410	71
72	Current Year Purchases	34,996	5,851	5,851			5,851	72
73	Fully Depreciated Assets	2,425,705					2,425,705	73
74								74
75	TOTALS	\$ 3,073,941	\$ 43,040	\$ 43,040	\$		\$ 2,965,966	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Facility Business	2017 Dodge Van	2017	40,082	4,008	4,008		10	36,073	77
78	Facility Business	2024 Bus	2024	103,065	10,312	10,312		10	18,848	78
79										79
80	TOTALS			\$ 143,147	\$ 14,320	\$ 14,320	\$		\$ 54,921	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)	\$ 9,760,794	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 182,851	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,312)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,353,036	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	Retirement Center/Assisted Living/	\$	\$	\$	86
87	Apartments/ Duplex	25,930,596	699,224	13,587,522	87
88					88
89					89
90					90
91	TOTALS	\$ 25,930,596	\$ 699,224	\$ 13,587,522	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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		# of prescrpts						9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						10
11	Academic Education		hrs						11
12	Other (specify): <u>Pharmacy</u>	39, 2				52,970		52,970	12
13	Other (specify): <u>Therapy, Lab, X-Ray</u>	39, 3			309,094			309,094	13
14	TOTAL			\$		\$ 309,094	\$ 52,970	\$ 362,064	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.

SEE ACCOUNTANTS' PREPARATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 438,503	\$	1
2	Cash-Patient Deposits	2,554		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (6,880))	166,519		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,612		6
7	Other Prepaid Expenses	40,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 675,489	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,890		13
14	Buildings, at Historical Cost	31,163,651		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,234,567		16
17	Accumulated Depreciation (book methods)	(21,940,556)		17
18	Deferred Charges	9,572		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): Debt Service Reserves	830,057		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,590,181	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,265,670	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,165,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	959		28
29	Short-Term Notes Payable	907,270		29
30	Accrued Salaries Payable	359,248		30
31	Accrued Taxes Payable (excluding real estate taxes)	196,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,479		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	557,243		36
37	Deferred Revenue - R.E. Tax	995,824		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,293,651	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,543,422		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	55,419		43
44	Lease Deposits	260,800		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,859,641	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,153,292	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,887,622)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,265,670	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (970,058)	1
2	Restatements (describe):		2
3	2024 Audit Adjustment for Real Estate Tax Exemption	363,955	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (606,103)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,281,519)	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)	\$ (1,281,519)	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)	\$ (1,887,622)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,470,561	1
2	Discounts and Allowances for all Levels	(134,692)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,335,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	457	5
6	Therapy	139,391	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 139,848	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	8,761	13
14	Non-Patient Meals	35,291	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	5,265	21
22	Laundry	6,280	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,597	23
	D. Non-Operating Revenue		
24	Contributions	112,749	24
25	Interest and Other Investment Income***	8,544	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121,293	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/IL/Duplexes</u>	4,239,302	28
28a	<u>QIP/CNA Incentive/Miscellaneous</u>	149,391	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,388,693	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,041,300	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,845,866	31
32	Health Care	3,030,659	32
33	General Administration	1,290,832	33
	B. Capital Expense		
34	Ownership	208,631	34
	C. Ancillary Expense		
35	Special Cost Centers	372,220	35
36	Provider Participation Fee	318,933	36
	D. Other Expenses (specify):		
37	<u>AL/IL/Duplexes</u>	4,255,678	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,322,819	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,281,519)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,281,519)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 561,921.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	613,063.00	45
46	MMAI-Medicaid is the Primary Payer	102,929.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,879,199.00	48
49	Medicare Part A	812,444.00	49
50	Other-(specify) <u>Managed Care</u>	366,313.00	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)	\$ 5,335,869	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,608	1,852	\$ 86,009	\$ 46.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,528	14,632	632,959	43.26	3
4	Licensed Practical Nurses	19,746	22,034	867,041	39.35	4
5	CNAs & Orderlies	46,583	50,822	1,152,652	22.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,631	1,825	33,238	18.21	9
10	Activity Assistants	1,738	1,463	22,198	15.17	10
11	Social Service Workers	1,933	2,247	40,820	18.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,481	8,216	184,458	22.45	17
18	Housekeepers	5,911	6,693	104,275	15.58	18
19	Laundry	5,911	6,693	104,275	15.58	19
20	Administrator	921	1,076	76,345	70.95	20
21	Assistant Administrator	942	945	41,876	44.31	21
22	Other Administrative	2,470	3,195	79,208	24.79	22
23	Office Manager					23
24	Clerical	2,780	3,219	49,734	15.45	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	1,259	1,400	21,037	15.03	31
32	Other Health Care(specify)					32
33	Other(specify) SR N MTN & BEA	807	807	12,336	15.29	33
34	TOTAL (lines 1 - 33)	115,249	127,119	\$ 3,508,461 *	\$ 27.60	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		20,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,442	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,719	11, 3	44
45	Social Service Consultant		1,719	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,680		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	% Ownership	Amount	Description		Amount	Description	Amount
Sara McMahan	Administrator	0	\$ 76,345	Workers' Compensation Insurance		\$ 40,954	IDPH License Fee	\$ 1,990
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	4,046
				FICA Taxes		228,634	Health Care Worker Background Check (Indicate # of checks performed _____)	1,587
				Employee Health Insurance		257,828	Patient Background Checks	
				Employee Meals			Association Dues (total from pg 22, #4)	8,217
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	1,423
				401k		20,299	Advertising/Marketing/Public Relations	9,813
				General Incentives		10,620		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,345				Less: Public Relations Expense	(9,813)
B. Administrative - Other							PAC and Lobbying payments	(2,585)
Description			Amount				All non-allowable advertising	()
Flowers/Memorials			\$ 309				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,678
Fines/Penalties			58,403					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 58,712	TOTAL (agree to Schedule V, line 22, col.8)		\$ 558,335		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Company, LLC	Audit/Cost Reports		\$ 14,850	N/A		\$	Out-of-State Travel	\$
Mathis, Marifian & Richter	Legal Fees		759					
							In-State Travel	
							Seminar Expense	
							Healthcare Academy eLearning	3,000
							Online Training	1,130
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,609	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,130

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	5,632
	5,632 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.

IL HEALTHCARE ASSOCIATION (IHCA)	2,585
	2,585 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	8,217
	8,217 Total
- (5)

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

\$ 38,661 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.

\$ 318,933

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. \$ 35,291
- (12)

Travel and Transportation

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

No If YES, attach a complete explanation.

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

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

Yes

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

Yes

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

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

No
- (13)

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

Firm Name: C.J. Schlosser & Co. L.L.C.

Yes
- (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.