

		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: 0052589

Facility Name: Elmhurst Extended Care Ctr

Address: 200 East Lake Street Elmhurst 60126
Number City Zip Code

County: DuPage

Telephone Number: (630) 516-5000 Fax # (630) 834-0480

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2014

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☐ Corporation	☐ Other
	☒ "Sub-S" Corp.	
	☐ Limited Liability Co.	
	☐ Trust	
	☐ Other	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Andrew B. Cutler Managing Director, Healthcare	
	(Firm Name & Address)	FGMK, LLC 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015	
	(Telephone)	(847) 940-3269 Fax # (847) 964-5469	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630		

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	664	3,635	1,581		2,321	4,347	3,744	16,292	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	664	3,635	1,581		2,321	4,347	3,744	16,292	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 41.33%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 12/31/2013

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/31/2013 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 108

Medicare Intermediary Wellpoint Federal

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2025 Ending: 12/31/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	331,209	19,608	6,524	357,341		357,341		357,341			1
2	Food Purchase		217,894		217,894		217,894		217,894			2
3	Housekeeping	162,327	19,392		181,719		181,719		181,719			3
4	Laundry	49,202	8,387		57,589		57,589		57,589			4
5	Heat and Other Utilities			128,576	128,576		128,576		128,576			5
6	Maintenance	37,752		164,690	202,442		202,442	(37,374)	165,068			6
7	Other (specify):*											7
8	TOTAL General Services	580,490	265,281	299,790	1,145,561		1,145,561	(37,374)	1,108,187			8
	B. Health Care and Programs											
9	Medical Director			59,100	59,100		59,100		59,100			9
10	Nursing and Medical Records	2,179,484	125,671	318,846	2,624,001		2,624,001		2,624,001			10
10a	Therapy											10a
11	Activities	108,326	183	4,391	112,900		112,900		112,900			11
12	Social Services	63,130			63,130		63,130		63,130			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,350,940	125,854	382,337	2,859,131		2,859,131		2,859,131			16
	C. General Administration											
17	Administrative	124,311			124,311		124,311		124,311			17
18	Directors Fees											18
19	Professional Services			213,490	213,490		213,490		213,490			19
20	Dues, Fees, Subscriptions & Promotions			24,521	24,521		24,521	(7,458)	17,063			20
21	Clerical & General Office Expenses	381,293	12,327	130,850	524,470		524,470	(76,508)	447,962			21
22	Employee Benefits & Payroll Taxes			536,920	536,920		536,920		536,920			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			266,772	266,772		266,772		266,772			26
27	Other (specify):*											27
28	TOTAL General Administration	505,604	12,327	1,172,553	1,690,484		1,690,484	(83,966)	1,606,518			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,437,034	403,462	1,854,680	5,695,176		5,695,176	(121,340)	5,573,836			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			17,018	17,018		17,018	107,090	124,108			30
31	Amortization of Pre-Op. & Org.							21,864	21,864			31
32	Interest							128,967	128,967			32
33	Real Estate Taxes			30,800	30,800		30,800	48,208	79,008			33
34	Rent-Facility & Grounds			359,993	359,993		359,993	(354,200)	5,793			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			407,811	407,811		407,811	(48,071)	359,740			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	312,646	169,846	36,128	518,620		518,620		518,620			39
40	Barber and Beauty Shops			2,299	2,299		2,299	(2,299)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,957	142,957		142,957		142,957			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	312,646	169,846	181,384	663,876		663,876	(2,299)	661,577			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,749,680	573,308	2,443,875	6,766,863		6,766,863	(171,710)	6,595,153			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	1,869	30		9
10	Interest and Other Investment Income	(68)	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	(29,400)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,134)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,071)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,397)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,201)		\$	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)	(25,509)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (25,509)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (171,710)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(2,324)	20	2
3	Barber and Beauty Offset	(2,299)	40	3
4	Non-Allowable Bank Charges	(1,558)	21	4
5	Non-Allowable Covid-19 Fees	(68,842)	21	5
6	Capitlaized R&M	(37,374)	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
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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	(112,397)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 354,200	LKNY, LLC		\$	(354,200)	1
2	V	30	Depreciation Expense		LKNY, LLC		105,221	105,221	2
3	V	31	Amortization Expense		LKNY, LLC		21,864	21,864	3
4	V	32	Mortgage Interest		LKNY, LLC		129,035	129,035	4
5	V	33	Real Estate Tax Expense	30,800	LKNY, LLC		79,008	48,208	5
6	V	21	Professional Fees		LKNY, LLC		24,363	24,363	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 385,000			\$ 359,491	\$ * (25,509)	14

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					LKNY, LLC	Elmhurst, IL	Bldg. Prtnrshp	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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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	Love Dave	Owner	Administrative	3.75	None	40	100.00	Salary	\$ 108,368	17-1	1
2	Madusudan Dave	Owner	Administrative	15.00	None	40	100.00	Salary	86,400	21-1	2
3	Dipti Dave	Owner	Bookkeeping	6.25	None	25	100.00	Salary	54,400	21-1	3
4	Sanju Mathew	Owner	Administrative	25.00	None	40	100.00	Salary	39,354	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 288,522		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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Greystone/HUD		X	Mortgage			\$ 5,570,336					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$ 5,570,336					\$	9
	B. Non-Facility Related*												
10	Interset Income Offset		X									(68)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (68)	14
15	TOTALS (line 9+line14)						\$ 5,570,336					\$ (68)	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

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.		\$	19,513	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.)				\$	79,008	2
3. Under or (over) accrual (line 2 minus line 1).				\$	59,495	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	19,513	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.				\$	79,008	7
Assessed Value from Real Estate Tax Bill:	2024	1,290,131	8			
Real Estate Tax Bill for Calendar Year:	2020	61,820	9			
	2021	65,364	10			
	2022	68,152	11			
	2023	73,196	12			
	2024	79,008	13			
Partial Real Estate Tax Accrual - Estimated at approximatly same as prior 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 Elmhurst Extended Care Ctr COUNTY DuPage
FACILITY IDPH LICENSE NUMBER 0052589
CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler
TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

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

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 33,019
- B. General Construction Type: Exterior BrickFrame Steel/WoodNumber of Stories 2
- C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. List the bed capacity for the building if it differs from the licensed total. N/A
- G. Have you properly capitalized all major repairs and equipment purchases? Yes
- H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- I. Are you presently operating under a sublease agreement? No
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

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

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

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Residential Care	41,851	2013	\$ 92,016	1
2	Parking Lot		2013	6,950	2
3	TOTALS	41,851		\$ 98,966	3

Facility Name & ID Number Elmhurst Extended Care Ctr

0052589

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	108		2013		\$ 2,860,030	\$	27	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2014		84,438		20			9
10	Various		2015		99,493		20			10
11	Various		2016		20,450		20			11
12	Various		2017		32,823		20			12
13	Various		2018		22,536		20			13
14	Various		2019		7,058		20			14
15	Replace 4" Drain Pipe - Plumbing Near Elevator		2020		3,025		20			15
16	Boiler Installation		2021		35,489		20			16
17	Power Supply Auto Door Closure		2021		2,527		20			17
18	Tempering Valve - Mechanical Roon		2022		4,915		20			18
19	6 Foot Fencing Trash Enclosure		2022		5,410		20			19
20	Emergency Stop Switch - Boiler		2022		2,501		20			20
21	Buckeye Power - Power Panel for Generator		2024		20,711		20			21
22	Buckeye Power - Generator Repairs		2025		32,757		20			22
23	Colley Elevator - Elevator Repair		2025		4,617		20			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	Current Depreciation					17,018		18,887		339,570

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$3,238,780	\$17,018		\$18,887	\$	\$339,570	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$27,572	\$	\$	\$	5	\$	71
72	Current Year Purchases	2,525				5		72
73	Fully Depreciated Assets	2,660,135						73
74								74
75	TOTALS	\$2,690,232	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,027,978	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$17,018	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$18,887	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$339,570	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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	Office Storage Renta;				5,793			6
7	TOTAL				\$ 5,793			7

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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	39-1	hrs	\$ 101,320		\$	\$		\$ 101,320	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	10,079					10,079	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	201,247					201,247	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				169,846		169,846	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray Fees	39-3				36,128			36,128	12
13	Other (specify):									13
14	TOTAL			\$ 312,646		\$ 36,128	\$ 169,846		\$ 518,620	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 778	\$ 1,000,676	1
2	Cash-Patient Deposits	940	940	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,601,119	1,651,119	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75	(75)	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,000	811,467	8
9	Other(specify): <u>Due from Employee</u>	3,961	3,961	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,609,873	\$ 3,468,088	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		493,227	13
14	Buildings, at Historical Cost		2,486,821	14
15	Leasehold Improvements, at Historical Cost	260,644	667,414	15
16	Equipment, at Historical Cost	171,811	3,030,252	16
17	Accumulated Depreciation (book methods)	(339,570)	(4,230,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ROU Asset</u>	1,492,782	1,492,782	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,585,667	\$ 3,939,540	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,195,540	\$ 7,407,628	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,075	\$ 173,075	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		105,599	29
30	Accrued Salaries Payable	52,106	52,106	30
31	Accrued Taxes Payable (excluding real estate taxes)	62,004	62,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deposit/Overpayment Ins/Due LKNY</u>	913,730	913,730	36
37	<u>Lease Liablt/Due to Owners LT Note</u>	5,388,984	5,388,984	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,589,899	\$ 6,745,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,009,107	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,009,107	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,589,899	\$ 11,754,605	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,394,359)	\$ (4,346,977)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,195,540	\$ 7,407,628	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,902,401)	1
2	Restatements (describe):		2
3	P/Y Adjustment	(215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,902,616)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,491,743)	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)	\$ (1,491,743)	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)	\$ (3,394,359)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmhurst Extended Care Ctr

0052589

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,188,852	1
2	Discounts and Allowances for all Levels	(907,505)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,281,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	757,426	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 757,426	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	3,354	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	155,542	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,703	19
20	Radiology and X-Ray	10,472	20
21	Other Medical Services	22,961	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 211,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 68	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	8,107	28
28a	Thrid Party Settlement	17,140	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,247	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,275,120	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,145,561	31
32	Health Care	2,859,131	32
33	General Administration	1,690,484	33
	B. Capital Expense		
34	Ownership	407,811	34
	C. Ancillary Expense		
35	Special Cost Centers	520,919	35
36	Provider Participation Fee	142,957	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,766,863	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,491,743)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,491,743)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 592,248.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,259,742.00	45
46	MMAI-Medicaid is the Primary Payer	105,133.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,629,478.00	48
49	Medicare Part A	694,746.00	49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,281,347	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,380	2,380	\$ 163,096	\$ 68.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,436	15,436	846,310	54.83	3
4	Licensed Practical Nurses	7,091	7,091	331,985	46.82	4
5	CNAs & Orderlies	29,647	29,647	838,093	28.27	5
6	CNA Trainees					6
7	Licensed Therapist	5,662	5,662	312,646	55.22	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,658	1,658	48,436	29.21	9
10	Activity Assistants	2,634	2,634	59,890	22.74	10
11	Social Service Workers	2,405	2,405	63,130	26.25	11
12	Dietician	331	331	14,186	42.86	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,200	13,200	317,023	24.02	15
16	Dishwashers					16
17	Maintenance Workers	1,708	1,708	37,752	22.10	17
18	Housekeepers	5,721	5,721	162,327	28.37	18
19	Laundry	1,878	1,878	49,202	26.20	19
20	Administrator	1,787	1,787	124,311	69.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,121	5,121	381,293	74.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,659	96,659	\$ 3,749,680 *	\$ 38.79	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,524	1-3	35
36	Medical Director	Monthly	59,100	9-3	36
37	Medical Records Consultant	3	156	10-3	37
38	Nurse Consultant	Monthly	4,434	10-3	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	Dialysis	Monthly	13,997	10-3	47
48					48
49	TOTAL (lines 35 - 48)	3	\$ 84,211		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,584	\$ 126,755	10-3	50
51	Licensed Practical Nurses	1,287	95,062	10-3	51
52	Certified Nurse Assistants/Aides	1,743	78,442	10-3	52
53	TOTAL (lines 50 - 52)	4,614	\$ 300,259		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Love Dave	Administrator	3.75%	\$ 108,368	Workers' Compensation Insurance	\$ 56,813	IDPH License Fee	\$ 8,485				
Valerie Buniao	Administrator	0	15,943	Unemployment Compensation Insurance	89,770	Advertising: Employee Recruitment	8,485				
				FICA Taxes	285,760	Health Care Worker Background Check					
				Employee Health Insurance	104,232	(Indicate # of checks performed 170)	1,679				
				Employee Meals		Patient Background Checks 106	1,060				
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	7,387				
				Employee Physicals	345	Dues and Subscriptions	776				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 124,311								
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$								
(Attach a copy of any management service agreement)											
C. Professional Services				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			
			\$			\$					
Elevate	Therapy Management		24,390				Out-of-State Travel	\$			
Polsinelli	Legal		29,963								
FGMK, LLC	Accounting/Tax/ Consulting		21,995								
CDH PC/Lisa Macias	Bookkeeping		15,931				In-State Travel				
Computer Medics	Data Processing/Computers		102,742								
Wellsky	Accounting		5,000								
Paycor	Accounting		2,481				Seminar Expense				
Rck, Fusco & Connelly, LLC	Legal		2,430								
Keith Goldberg	Legal		8,498								
Fred Hiken	Legal		60								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL							
(For legal fee disclosure, see page 39 of instructions)			\$ 213,490				Entertainment Expense	()			
							(agree to Sch. V,				
							line 24, col. 8)	\$			

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

5,063

5,063

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)

2,324

2,324

Total

(4)

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

IL HEALTHCARE ASSOCIATION (IHCA)

7,387

7,387

Total

(5)

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

\$ 18,245

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.

\$ 142,957

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.

\$ No

Has any meal income been offset against
related costs? Indicate the amount. \$ N/A

(12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a
program during this reporting period. \$ N/A

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

LN 14

d. Have vehicle usage logs been maintained?

No

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

No

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: N/A

No

(14)

Have all costs which do not relate to the provision of long term care been adjusted out
of Schedule V?

Yes

(15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.