

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0021568

Facility Name: The Elms

Address: 1212 Madelyn Avenue Macomb 61455
Number City Zip Code

County: Mcdonough

Telephone Number: (309) 837-5482 Fax # (309) 833-1054

HFS ID Number:

Date of Initial License for Current Owners: 10/11/1977

Type of Ownership:

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

☐ PROPRIETARY
☒ GOVERNMENTAL
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☒ State
☒ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: 630-361-2868
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 12/01/2024 to 11/30/2025 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 ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/01/2024 Ending: 11/30/2025

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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						2,545	1,321	3,866	8
9	SNF/PED									9
10	ICF	5,192	7,111	3,091		6,729			22,123	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,192	7,111	3,091		6,729	2,545	1,321	25,989	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 72.66%

SEE ACCOUNTANTS' PREPARATION REPORT

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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/11/1977

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 49

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 11/30/25 Fiscal Year: 11/30/25

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

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	416,895	46,446	36,786	500,127		500,127		500,127			1
2	Food Purchase		432,885		432,885		432,885	(5,472)	427,413			2
3	Housekeeping	196,793	29,757		226,550		226,550		226,550			3
4	Laundry	90,771	6,369	78,100	175,240		175,240		175,240			4
5	Heat and Other Utilities			171,789	171,789		171,789		171,789			5
6	Maintenance	165,465	54,109	41,919	261,493		261,493		261,493			6
7	Other (specify):* Waste Disposal			15,298	15,298		15,298		15,298			7
8	TOTAL General Services	869,924	569,566	343,892	1,783,382		1,783,382	(5,472)	1,777,910			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	4,064,402	426,259	678,621	5,169,282		5,169,282	(23,294)	5,145,988			10
10a	Therapy											10a
11	Activities	102,471	6,859	1,000	110,330		110,330		110,330			11
12	Social Services	73,773	306	1,000	75,079		75,079		75,079			12
13	CNA Training											13
14	Program Transportation			11,326	11,326		11,326		11,326			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,240,646	433,424	699,147	5,373,217		5,373,217	(23,294)	5,349,923			16
	C. General Administration											
17	Administrative	113,392			113,392		113,392		113,392			17
18	Directors Fees											18
19	Professional Services			164,999	164,999		164,999	5,446	170,445			19
20	Dues, Fees, Subscriptions & Promotions			47,548	47,548		47,548	213	47,761			20
21	Clerical & General Office Expenses	201,444	19,193	10,454	231,091		231,091	9,627	240,718			21
22	Employee Benefits & Payroll Taxes			1,941,202	1,941,202		1,941,202	2,342	1,943,544			22
23	Inservice Training & Education			4,600	4,600		4,600		4,600			23
24	Travel and Seminar			2,933	2,933		2,933		2,933			24
25	Other Admin. Staff Transportation			508	508		508		508			25
26	Insurance-Prop.Liab.Malpractice							58,745	58,745			26
27	Other (specify):*											27
28	TOTAL General Administration	314,836	19,193	2,172,244	2,506,273		2,506,273	76,373	2,582,646			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,425,406	1,022,183	3,215,283	9,662,872		9,662,872	47,607	9,710,479			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							159,929	159,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,855	4,855		4,855		4,855			35
36	Other (specify):*											36
37	TOTAL Ownership			4,855	4,855		4,855	159,929	164,784			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,495	487,642	717,137		717,137		717,137			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,050	141,050		141,050		141,050			42
43	Other (specify):* Disallowed Costs	66,584	3,955	178,049	248,588		248,588	(248,588)				43
44	TOTAL Special Cost Centers	66,584	233,450	806,741	1,106,775		1,106,775	(248,588)	858,187			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,491,990	1,255,633	4,026,879	10,774,502		10,774,502	(41,052)	10,733,450			45

*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

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	(2,381)	2		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	159,929	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3,091)	2		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	(315)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,765)	43		24
25	Fund Raising, Advertising and Promotional	(25,239)	43		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 See Page 5A	(74,277)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,139)		\$	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)	61,087		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,087		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (41,052)		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	\$ (3,716)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7	Disallow Marketing Wages	(66,584)	43	7
8	Amortize Wifi License	4,244	20	8
9	Capitalize Expensed Equipment over \$2,500	(23,294)	10	9
10				10
11				11
12				12
13				13
14	Farm Account:			14
15	Life Loop - Computer Services	5,446	19	15
16	Internet	9,627	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,277)		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 Board of Directors on Page Ownership Listing-1		N/A		Mcdonough County		Local Gov't Unit
				Macomb Public Bldg Commission		Local Gov't Unit

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	22	Workman's Compensation Insurance	\$	McDonough County	100.00%	\$ 2,342	\$ 2,342	1
2	V	26	Property/Auto/Liability Insurance		McDonough County	100.00%	58,745	58,745	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			\$			\$ 61,087	\$ * 61,087	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Ownership Listing-1

The Elms

ID#0021568

Report Period Beginning:12/01/2024

Ending:11/30/2025

N/A

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1	Board of Directors:							1
2								2
3	Larry		Aurelio	Macomb	IL			3
4	Eric		Blakeley	Colchester	IL			4
5	Eric		Chapman	Bushnell	IL			5
6	Clayton		Cook	Good Hope	IL			6
7	David		Cortelyou	Bushnell	IL			7
8	Mike		Cox	Macomb	IL			8
9	Ken		Durkin	Macomb	IL			9
10	Joe		Erlandson	Macomb	IL			10
11	Craig		Foster	Bushnell	IL			11
12	Allen		Henderson	Macomb	IL			12
13	Travis		Hiel	Prairie City	IL			13
14	Vicky		Kipling	Macomb	IL			14
15	Michael		Kirby	Macomb	IL			15
16	Ryan		Litchfield	Macomb	IL			16
17	Jack		Lowderman	Macomb	IL			17
18	Clayton		Murphy	Bushnell	IL			18
19	Jerry		Raby	Colchester	IL			19
20	Jarad		Royer	Industry	IL			20
21	Terry		Thompson	Macomb	IL			21
22	Dana Roy		Walker	Macomb	IL			22
23	Roger		Ward	Macomb	IL			23
24								24
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74								74
75								75

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Note: No services are provided to the nursing home by Board members or their relatives								\$		1
2	See Page Ownership-1 for a list of Board members										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/01/2024 Ending: 1/30/2025

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 McDonough County
Street Address One Courthouse Square, #7
City / State / Zip Code Macomb, Illinois 61455
Phone Number (309) 837-2308
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	22	Workman's Compensation Insura	Direct Allocation	2,342	1	\$ 2,342	\$	2,342	\$ 2,342	1
2	26	Property/Auto/Liability Insurance	Direct Allocation	58,745	1	58,745		58,745	58,745	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 61,087	\$		\$ 61,087	25

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ None	Line #	N/A
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*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.**

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

**** 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

FACILITY NAME	<u>The Elms</u>	COUNTY	<u>McDonough</u>
---------------	-----------------	--------	------------------

CONTACT PERSON REGARDING THIS REPORT Larry Templin

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,100 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
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?
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 NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Nursing Home	7 Acres	1975	\$ 49,000	1
2					2
3	TOTALS			\$ 49,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2009	\$ 408,520	\$	20	\$ 20,426	\$ 20,426	\$ 347,242	37
38	Various	2010	63,730		20	3,188	3,188	50,995	38
39	Various	2011	24,478		20	1,224	1,224	19,722	39
40	Various	2012	15,346		20	767	767	10,740	40
41	Various	2013	18,065		20	903	903	11,741	41
42	Various	2014	3,634		20	182	182	2,182	42
43	Various	2015	290,663		20	14,532	14,532	159,860	43
44	Various	2016	7,277		20	364	364	3,639	44
45	Various	2017	587,709		20	29,385	29,385	264,467	45
46	Front Lobby Air Conditioner Repair	2018	3,741		20	187	187	1,496	46
47	Generator Repair	2018	4,095		20	205	205	1,640	47
48	New Laminate Floors - South Main Dining Room	2018	41,208		20	2,060	2,060	16,481	48
49	Concrete Replacement	2018	2,870		20	144	144	1,151	49
50	Window Treatments-Dining Rm - Roller Shades & Cornice Board	2018	7,608		20	380	380	2,660	50
51	Heater Repair	2019	2,704		20	135	135	945	51
52	Sump Sensor And Cpu Board Replacement	2019	2,636		20	132	132	924	52
53	120 Gallon Water Heater	2019	9,787		20	489	489	3,423	53
54	Sewer Lining Repair	2019	134,500		20	6,725	6,725	47,075	54
55	New Freezer Door And Surrounding Panel Assembly	2019	5,848		20	292	292	2,044	55
56	Heat Pump Installation	2019	10,355		20	518	518	3,108	56
57	New Walk In Cooler Door, Surrounding Panel Assembly	2019	6,233		20	312	312	1,872	57
58	New Gutters	2020	24,750		20	1,238	1,238	7,428	58
59	Heat Pump Installation - Kitchen	2020	8,872		20	444	444	2,664	59
60	General Failure Repair - Change Oil And Filters	2020	3,878		20	194	194	1,164	60
61	Door Openers	2021	5,961		20	298	298	1,490	61
62	Roof & Gutter Repairs	2021	16,800		20	840	840	4,200	62
63	Seal Cracks And Seal Coat Parking Lot	2021	16,827		20	421	421	2,105	63
64	Furnish And Install Climate Master Heat Pump	2021	7,937		20	397	397	1,985	64
65	Water Heater	2022	11,900		20	595	595	2,083	65
66	Installation of Ductless Heat Pump in IT room	2023	6,760		20	338	338	845	66
67	Add Expansion Tank to Anti-Freeze Loop	2023	6,500		20	325	325	975	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,495,989	\$		\$ 132,170	\$ 131,460	\$ 4,635,768	70

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 12A, Carried Forward		\$ 5,495,989	\$		\$ 132,170	\$ 132,170	\$ 4,635,768	1
2	Nurse Call System	2024	178,017		20	8,901	8,901	13,351	2
3	Install five 15,000 Console Units-Dining Rooms	2024	26,760		20	1,338	1,338	2,007	3
4	Furnished and Installed 4 Ton Climatemaster Heat Pumps	2024	9,671		20	484	484	726	4
5	Install three 15,000 Console Units-Dining Rooms	2024	11,567		20	578	578	867	5
6	Furnished and Installed 10 Islandaire Console Heaters	2024	19,361		20	968	968	1,452	6
7	Repair Cooling Tower-Replaced Bearing and Shaft	2024	5,581		20	279	279	279	7
8	Remodel South Bathroom-Replace/Install Tile, Plumbing	2025	26,527		20	663	663	663	8
9	Installed New Cold Water Feed-North Hallway	2025	28,300		20	708	708	708	9
10	Cooling Tower-Replace 140 ft of 6 in Pipe, Remove/Replace								10
11	Sidewalk, Refill 70 ft Trench	2025	33,900		20	848	848	848	11
12	Remodel North Bathroom-Replace/Install Tile, Plumbing	2025	25,602		20	640	640	640	12
13	Repair Water Line-Sotuh Dining Room	2025	8,967		20	224	224	224	13
14	PTAC Units (10)	2025	17,431		20	436	436	436	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,887,673	\$		\$ 148,237	\$ 148,237	\$ 4,657,969	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	\$ 968,420	\$	\$ 9,012	\$ 9,012	10 Yrs	\$ 904,796	71
72	Current Year Purchases	23,294		1,462	1,462	10 Yrs	1,462	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 991,714	\$	\$ 10,474	\$ 10,474		\$ 906,258	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		2004 Chevy Truck	2004	\$ 24,869	\$	\$	\$	5	\$ 24,869	76
77		1997 Dodge Van	1997	16,993				5	16,993	77
78		2005 Van	2008	19,500				5	19,500	78
79		See Attached Schedule 13A		86,092		1,218	1,218		81,831	79
80	TOTALS			\$ 147,454	\$	\$ 1,218	\$ 1,218		\$ 143,193	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)	\$ 7,075,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,929	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 159,929	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,707,420	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	Farmland (5 Acres) - 1993	\$ 12,427	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 12,427	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

Facility Name: The Elms
IDPH License ID Number: 0021568
Fiscal Year End: 11/30/2025

Schedule 13A

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		Bus	2015	\$ 55,004	\$	\$	0	5	\$ 55,004	76
77		2020 Van	2020	25,000			0	5	25,000	77
78		2015 Chrysler Town & Country-Transmission Repair	2024	6,088		1,218	1,218	5	1,827	78
79							0			79
80	TOTALS			\$ 86,092	\$ 0	\$ 1,218	\$ 1,218		\$ 81,831	80

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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: \$ 4,855 Description: Copier
(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	N/A				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
		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	39(3)	hrs	\$	4,907	\$ 157,900	\$	4,907	\$ 157,900	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,524	122,964		1,524	122,964	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		6,120	186,551	11,133	6,120	197,684	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				194,822		194,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab/X-Ray</u>					20,227			20,227	12
13	Other (specify): <u>Oxygen</u>						23,540		23,540	13
14	TOTAL			\$	12,551	\$ 487,642	\$ 229,495	12,551	\$ 717,137	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,335,854	\$ 1,335,854	1
2	Cash-Patient Deposits	10,779	10,779	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,517,700	1,517,700	3
4	Supply Inventory (priced at <u>Cost</u>)	78,279	78,279	4
5	Short-Term Investments	2,515,754	2,515,754	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(1,413)	1,770	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule 17A</u>	478,626	478,626	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,935,579	\$ 5,938,762	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,426	61,427	13
14	Buildings, at Historical Cost	4,495,548	5,887,673	14
15	Leasehold Improvements, at Historical Cost	444,872		15
16	Equipment, at Historical Cost	902,012	1,139,168	16
17	Accumulated Depreciation (book methods)	(4,327,455)	(5,707,420)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Constr in Progres	123,207		22
23	Other(specify): <u>Def Outflow Resrcs-IMRF</u>	2,115,617	2,115,617	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,815,227	\$ 3,496,465	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,750,806	\$ 9,435,227	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 134,827	\$ 134,827	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,779	10,779	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,520	259,520	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	1,994,829	1,994,829	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,399,955	\$ 2,399,955	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Capital Lease Payable</u>	14,847	14,847	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 14,847	\$ 14,847	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,414,802	\$ 2,414,802	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,336,004	\$ 7,020,425	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,750,806	\$ 9,435,227	48

Facility Name:

The Elms

IDPH License ID Number:

0021568

Fiscal Year End:

11/30/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other

	Operating	After Consolidation
Accrued Property Taxes	409,530	409,530
Interest Receivable	69,096	69,096
TOTAL	478,626	478,626

Line 36 Other

	Operating	After Consolidation
Net OPEB Obligation	193,572	193,572
Net Pension Liability	1,255,149	1,255,149
Deferred Inflow Resources-IMRF	35,314	35,314
Deferred Revenue Property Taxes	409,530	409,530
Unearned Revenue	84,788	84,788
Other Accrued Expenses	16,476	16,476
TOTAL	1,994,829	1,994,829

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,774,274	1
2	Restatements (describe):		2
3	2024 Contributed Capital	(122,348)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,651,926	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(315,922)	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)	\$ (315,922)	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)	\$ 7,336,004	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning: 12/01/2024

Ending: 11/30/2025

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	\$ 9,752,553	1
2	Discounts and Allowances for all Levels	(385,583)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,366,970	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,101	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 147,101	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,381	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110,268	23
	D. Non-Operating Revenue		
24	Contributions	11,260	24
25	Interest and Other Investment Income***	80,819	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92,079	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	562,634	28
28a	QIP/C.N.A Initiative Revenue	179,528	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 742,162	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,458,580	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,783,382	31
32	Health Care	5,373,217	32
33	General Administration	2,506,273	33
	B. Capital Expense		
34	Ownership	4,855	34
	C. Ancillary Expense		
35	Special Cost Centers	965,725	35
36	Provider Participation Fee	141,050	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,774,502	40
41	Income before Income Taxes (line 30 minus line 40)**	(315,922)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (315,922)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 750,915	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,541,765	45
46	MMAI-Medicaid is the Primary Payer	1,104,851	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,271,239	48
49	Medicare Part A	1,456,510	49
50	Other-(specify) Managed Care	646,254	50
51	Other-(specify) Medicaid Hospice	595,436	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)	\$ 9,366,970	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:	The Elms
IDPH License ID Number:	0021568
Fiscal Year End:	11/30/2025

Schedule 19A

XVII. Income Statement

Line 28 Other

	Amount
Property Tax	382,734
Change In Fmv-Edward Jones	11,571
Contributed Capital-Fixed Asset	164,090
Rebate Income	3,091
Farm Rent	1,148
TOTAL	562,634

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	1,604	1,880	\$ 90,710	\$ 48.25	1
2	Assistant Director of Nursing	1,897	2,143	102,531	47.84	2
3	Registered Nurses	18,827	20,421	880,107	43.10	3
4	Licensed Practical Nurses	9,943	10,760	381,105	35.42	4
5	CNAs & Orderlies	75,350	100,722	2,358,797	23.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,200	2,143	71,937	33.57	9
10	Activity Assistants	1,667	2,018	30,534	15.13	10
11	Social Service Workers	1,558	2,079	73,773	35.48	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,135	49,761	23.31	13
14	Head Cook	6,033	6,905	128,527	18.61	14
15	Cook Helpers/Assistants	14,784	15,295	238,607	15.60	15
16	Dishwashers					16
17	Maintenance Workers	5,930	6,406	165,465	25.83	17
18	Housekeepers	10,501	11,586	196,793	16.99	18
19	Laundry	4,863	5,240	90,771	17.32	19
20	Administrator	1,984	2,143	113,392	52.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,246	9,077	201,444	22.19	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) See Pg 20A	6,566	7,312	317,736	43.45	33
34	TOTAL (lines 1 - 33)	172,894	208,265	\$ 5,491,990 *	\$ 26.37	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	339	\$ 36,786	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,245	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	1,000	L11, C3	44
45	Social Service Consultant	Quarterly	1,000	L12, C3	45
46	Other(specify) MDS Consultant	Monthly	767	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	339	\$ 53,998		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,601	\$ 246,659	L10, C3	50
51	Licensed Practical Nurses	2,879	154,466	L10, C3	51
52	Certified Nurse Assistants/Aides	8,032	267,361	L10, C3	52
53	TOTAL (lines 50 - 52)	14,512	\$ 668,486		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

The Elms

Period Beginning

12/01/2024

Period End

11/30/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator	4,757	5,169	251,152	48.59
Marketing	1,809	2,143	66,584	31.07
TOTAL	6,566	7,312	317,736	

Facility Name & ID Number		The Elms		STATE OF ILLINOIS		# 0021568		Report Period Beginning:		12/01/2024		Page 21		Ending: 11/30/2025	
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					
Jeff Howd		Administrator	0	\$ 113,392	Workers' Compensation Insurance		\$ 113,507	IDPH License Fee		\$					
					Unemployment Compensation Insurance		13,648	Advertising: Employee Recruitment				30,288			
					FICA Taxes		416,168	Health Care Worker Background Check							
					Employee Health Insurance		1,033,420	(Indicate # of checks performed 27)				1,029			
					Employee Meals			Patient Background Checks				1,800			
					Illinois Municipal Retirement Fund (IMRF)*		332,545	Association Dues (total from pg 22, #4)				10,348			
					Employee Physicals		10,641	Dues & Subscriptions				2,576			
					Other Employee Benefits		23,615	Licenses & Fees				1,507			
								Wifi License				4,244			

* 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?

Yes
- (2)

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

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	6,632
	6,632 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)	3,716
	3,716 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	10,348
	10,348 Total
- (5)

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

\$	60,289	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.

\$	141,050
----	---------

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?	Indicate the amount.	\$	2,381
	Yes				
- (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?

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (13)

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

Yes

Firm Name: Sikich Group, LLC
- (14)

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

Yes
- (15)

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

Yes

See page 39 of the instructions for details.

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