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: 0049718

Facility Name: Galena Stauss Nursing Home

Address: 215 Summit Street (Number) Galena (City) 61036 (Zip Code)

County: Jo Daviess

Telephone Number: (815) 776-1340 **Fax #** (815) 776-7274

HFS ID Number:

Date of Initial License for Current Owners: 01-01-1970

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 20-4560540			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kelli Jackson **Telephone Number:** (815) 776-7277
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 10/01/2024 to 09/30/2025 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) Tracy Bauer
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ 02/17/2026 (Date)
(Print Name and Title) Paul Traczek, CPA, Partner
(Firm Name & Address) Wipfli Advisory LLC, 4890 Owen Ayres Court, Eau Claire, WI 54701
(Telephone) (715) 858-6619 Fax # (715) 832-2345

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 Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	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	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF			6,738		7,589			14,327	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS			6,738		7,589			14,327	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 68.86%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 01/01/1970 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 5

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: 09/30/2025

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	241,529		68,394	309,923		309,923		309,923			1
2	Food Purchase		129,139		129,139		129,139		129,139			2
3	Housekeeping	76,983		22,314	99,297		99,297		99,297			3
4	Laundry			53,037	53,037		53,037		53,037			4
5	Heat and Other Utilities			35,457	35,457		35,457		35,457			5
6	Maintenance	34,274		45,279	79,553		79,553		79,553			6
7	Other (specify):*											7
8	**TOTAL General Services**	352,786	129,139	224,481	706,406		706,406		706,406			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,019,265		264,105	2,283,370		2,283,370		2,283,370			10
10a	Therapy	455			455		455		455			10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			42,013	42,013		42,013		42,013			15
16	**TOTAL Health Care and Programs**	2,019,720		306,118	2,325,838		2,325,838		2,325,838			16
	C. General Administration											
17	Administrative	115,747		61,398	177,145		177,145		177,145			17
18	Directors Fees											18
19	Professional Services			41,282	41,282		41,282		41,282			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	17,574		9,322	26,896		26,896		26,896			21
22	Employee Benefits & Payroll Taxes			617,761	617,761		617,761		617,761			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,321		729,763	863,084		863,084		863,084			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,505,827	129,139	1,260,362	3,895,328		3,895,328		3,895,328			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.

Facility Name & ID Number Galena Stauss Nursing Home #0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,151	35,151	(2,618)	32,533		32,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					2,618	2,618		2,618			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,297	3,297		3,297		3,297			35
36	Other (specify):*											36
37	**TOTAL Ownership**			38,448	38,448		38,448		38,448			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,078	275,078		275,078		275,078			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			275,078	275,078		275,078		275,078			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,505,827	129,139	1,573,888	4,208,854		4,208,854		4,208,854			45

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY									
48		49		50		51		52	

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

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

Galena Stauss Nursing Home

ID# 0049718

Report Period Beginning: 10/01/2024

Ending: 09/30/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 **Report Period Beginning:** 10/01/2024 **Ending:** 09/30/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

STATE OF ILLINOIS **Ownership Listing-1**

Galena Stauss Nursing Home

ID# **0049718**

Report Period Beginning: **10/01/2024**

Ending: **09/30/2025**

-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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
20									20
21									21
22									22
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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									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Galena Stauss Nursing Home

ID# **0049718**

Report Period Beginning: **10/01/2024**

Ending: **09/30/2025**

-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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
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149									149
150									150

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 9/30/2025

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 9/30/2025

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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	USDA		X	Refiance of old loan - NH portion		4/25/2019	$ 33,000,000	$ 29,080,680		3.5000	$ 2,618	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 33,000,000	$ 29,080,680			$ 2,618	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 33,000,000	$ 29,080,680			$ 2,618	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.)

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

FOR BHF USE ONLY

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Galena Stauss Nursing Home COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0049718

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** _____ **B. General Construction Type:** **Exterior** _____ **Frame** _____ **Number of Stories** _____

C. **Does the Operating Entity?** ☐ **(a) Own the Facility** ☐ **(b) Rent from a Related Organization.** ☐ **(c) Rent from Completely Unrelated Organization.**

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

D. **Does the Operating Entity?** ☐ **(a) Own the Equipment** ☐ **(b) Rent equipment from a Related Organization.** ☐ **(c) Rent equipment from Completely Unrelated Organization.**

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

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

_____

_____

_____

_____

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

G. Have you properly capitalized all major repairs and equipment purchases? _____

H. Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____

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

_____

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

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54			1971	$ 8,020	$	40	$	$	$ 8,020	4
5				1981	2,691		25			2,691	5
6				1988	7,977	199	40	199		7,461	6
7				2007	847,453	7,256	40	7,256		402,290	7
8											8
	Improvement Type**										
9	STOREROOM			1970	548		42			548	9
10	STOREROOM & MTC-GENERAL			1975	1,668		34			1,668	10
11	STOREROOM & MTC-ELECTRICAL			1975	178		20			178	11
12	STOREROOM & MTC-MECHANICAL			1975	382		25			382	12
13	PARKING LOT EXPAN.			1981	333		12			333	13
14	GENERAL CONTRACT			1985	1,502		24			1,502	14
15	ELECTRICAL			1985	913		20			913	15
16	MECHANICAL			1985	1,383		20			1,383	16
17	MILLWORK			1985	544		20			544	17
18	NEW ROOM-GIESE			1985	531		10			531	18
19	MILLWORK-BLDG ADD'N			1986	277		20			277	19
20	PLUMBING-BLDG ADD'N			1988	1,162		20			1,162	20
21	HEATING & A/C-BLDG ADD'N			1988	1,137		20			1,137	21
22	ELECTRICAL-BLDG ADD'N			1988	1,365		20			1,365	22
23	REMODELING-GENERAL			1988	2,458		27			2,458	23
24	PLUMBING			1994	218		20			218	24
25	HEATINGVENTINGAIR COND.			1994	514		20			514	25
26	ELECTRICAL			1994	1,002		20			1,002	26
27	SUSPENDED CEILING			1994	136		12			136	27
28	CABINETS			1994	341		20			341	28
29	FLOOR COVERINGS			1994	225		10			225	29
30	ELEVATOR			1994	552		20			552	30
31	ELECTRICAL-RADIOLOGY REMODEL			1994	628		18			628	31
32	GENERAL-RADIOLOGY REMODELING			1996	1,452		20			1,452	32
33	PHYSICAL THERAPY ROOM REMODEL			1996	194		20			194	33
34	ARMSTRONG TILE FLOORING FOR DIETARY			1997	60		20			60	34
35	PARKING LOT			2000	1,174		15			1,174	35
36	LANDSCAPING & PARKING LOT			2000	1,824		15			1,824	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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	FIRE ALARM SYSTEM-ADMINISTRATION	2000	$ 42	$	15	$	$	$ 42	37
38	REMODELING-BUSINESS OFFICE	2001	2,951		15			2,951	38
39	HOOD & EXHAUST WORK - DIETARY	2001	42		15			42	39
40	2 TREES	2001	6		20			6	40
41	HANDICAP ENTRANCE	2002	34		20			34	41
42	REPAIR TO SIDEWALK (CLINIC/NH)	2002	53		15			53	42
43	2 TREES	2002	4		15			4	43
44	RADIOLOGY REMODEL	2002	1,116		20			1,116	44
45	NURSING HOME NEW CEILING	2002	130		15			130	45
46	NURSING HOME SHOWER FLOORS	2002	22		10			22	46
47	NURSING HOME REMODEL	2002	144		20			144	47
48	HAND RAIL FOR PHYSICAL THERAPY	2002	14		10			14	48
49	NURSING HOME THERMOSTATS & ELECTRIC	2002	113		15			113	49
50	AUTOMATIC ENTRANCE MED-SURG	2003	349		10			349	50
51	ADMINISTRATION REMODEL	2003	255		5			255	51
52	HOSPITAL GENERATOR POWER SOURCE	2003	232		15			232	52
53	ELECTRICAL WORK	2003	174		5			174	53
54	DENSITOMETER ROOM	2003	191		20			191	54
55	CIRCULATING BOOSTER PUMP	2004	126		5			126	55
56	PT REMODEL	2004	374		10			374	56
57	CT REMODEL	2004	2,719	68	15	68		2,719	57
58	ELEVATOR PROCESSOR BOARD	2005	46		20			46	58
59	ER REMODEL/SHOWER ROOM	2005	78		5			78	59
60	GARAGE DOOR	200	20		15			20	60
61	FLOORING	2006	11		10			11	61
62	HEATING	2006	99		10			99	62
63	SPRINKLER SYSTEM	2007	1,053	42	15	42		779	63
64	SPRINKLER SYSTEM	2007	103	4	25	4		76	64
65	PLASTIC CULVERT PIPE	2007	68	3	25	3		63	65
66	Building Components/Remodeling - 2007 Nursing Home	2007	64	3	20	3		57	66
67	Deck	2007	232		20			232	67
68	Flooring	2010	20		10			20	68
69	Windows and Doors	2010	247	12	20	12		191	69
70	TOTAL (lines 4 thru 69)		$ 899,973	$ 7,589		$ 7,589	$	$ 453,927	70

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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	
1	Totals from Page 12A, Carried Forward		$ 899,973	$ 7,589		$ 7,589	$	$ 453,927	1
2	Replace Flat Roof at NH	2011	2,256					2,256	2
3	Replace Kitchen Ceiling in NH	2011	110					110	3
4	Landscaping	2011	34					34	4
5	Carpet and Flooring - Resident Rooms in NH	2012	316					316	5
6	Flooring - Vinyl - NH Dining Room and Nurses Station	2012	181					181	6
7	Resident Room Faucets in NH Patient Rooms	2012	98	5		5		61	7
8	Resident Room Vanity Countertops in NH Patient Rooms	2012	53	4		4		44	8
9	Flashed Roof Top Duct Work on NH Building	2013	22					22	9
10	Flooring	2015	148	7		7		148	10
11	Front Entrance Flooring	2016	149	15		15		141	11
12	Replacement Windows - NH	2017	219	11		11		82	12
13	Nurse Call System - Senior Care	2017	134	13		13		101	13
14	LVT Flooring	2019	585	29		29		161	14
15	Furnish and Window Install	2019	197	10		10		54	15
16	Boiler Replacement & Repiping System	2019	303	15		15		83	16
17	Furnish and Window Install	2020	117	6		6		32	17
18	MRI Upgrade PLBG-HVAC Work	2020	104	10		10		104	18
19	Blacktop	2021	194	24		24		109	19
20	Adjustment to agree to overall allocated depreciation	2025		17,538		17,538			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)		$ 905,194	$ 25,276		$ 25,276	$	$ 457,967	34

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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	$ 1,006,782	$ 7,257	$ 7,257	$	10	$ 984,248	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,006,782	$ 7,257	$ 7,257	$		$ 984,248	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)	$ 1,911,976	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,533	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,533	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,442,215	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.

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Nursing Home **#** 0049718 **Report Period Beginning:** 10/01/2024 **Ending:** 09/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/2025 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,697,013	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,794,715)	5,307,266		3
4	Supply Inventory (priced at)	542,899		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	515,151		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other receivables	1,339,794		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,402,123	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,263,115		12
13	Land	448,597		13
14	Buildings, at Historical Cost	82,691,564		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,978,271		16
17	Accumulated Depreciation (book methods)	(43,829,489)		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): Investment in unconsolidated affi	25,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,577,058	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 75,979,181	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,163,007	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,239,554		29
30	Accrued Salaries Payable	1,990,551		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	60,521		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits and Deferred Revenue	134,987		36
37	Amounts Payable to Medicare	467,639		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,056,259	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	59,618,644		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 59,618,644	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 64,674,903	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,771,918	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 76,446,821	$	48

***(See instructions.)**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,196,261	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,196,261	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,525,233	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) **Interest Income**	60,898	15
16	Other (describe) **Loans forgiven from temp restricted net assets**	(10,474)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,575,657	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)**	$ 11,771,918	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,207,948	1
2	Discounts and Allowances for all Levels	(669,949)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,537,999	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Hospital net income**	2,196,088	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,196,088	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,734,087	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	706,406	31
32	Health Care	2,325,838	32
33	General Administration	863,084	33
	B. Capital Expense		
34	Ownership	38,448	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	275,078	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,208,854	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,525,233	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,525,233	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,250,381.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,287,618.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,537,999	56

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,704	1,941	94,421	48.65	2
3	Registered Nurses	10,517	11,979	516,599	43.13	3
4	Licensed Practical Nurses	4,875	5,553	178,675	32.18	4
5	CNAs & Orderlies	30,921	35,218	792,516	22.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,875	3,274	71,461	21.83	8
9	Activity Director	1,683	1,917	48,168	25.13	9
10	Activity Assistants	4,255	4,846	112,254	23.16	10
11	Social Service Workers	1,312	1,494	49,295	33.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,435	8,468	234,908	27.74	15
16	Dishwashers					16
17	Maintenance Workers	969	1,104	33,703	30.53	17
18	Housekeepers	2,673	3,044	74,826	24.58	18
19	Laundry					19
20	Administrator	1,680	1,913	106,648	55.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,767	2,012	49,229	24.47	31
32	Other Health Care(specify)					32
33	Other(specify)	4,162	4,741	133,321	28.12	33
34	TOTAL (lines 1 - 33)	76,828	87,504	$ 2,496,024 *	$ 28.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Bauer	CEO		$
Brianne Van Hemert	NH Admin		
Amounts are allocated - see separate cost report for allocation to AL and ADL			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Supplies and allocated administrative expenses	$ 264,105
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 264,105

C. Professional Services

Vendor/Payee	Type	Amount
OS, Inc	NH billing services	$ 41,282
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 41,282

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Allocated benefits from Medicare cost report	617,761
TOTAL (agree to Schedule V, line 22, col.8)	$ 617,761

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Galena Stauss Nursing Home # 0049718 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

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

Association Name	Amount
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.

Total	

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

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **42,013** Line **15**

(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. $ **275,078**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **0**

d. Have vehicle usage logs been maintained? **N/A**

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

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. $

(13) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wipfli LLP**

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

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? **N/A** See page 39 of the instructions for details. **legal expenses related to NH in 2025**
Attach invoices and a summary of services for all architect and appraisal fees.