

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0036103

Facility Name: Garden Center Services

Address: 8345 S Austin Avenue Burbank 60459
Number City Zip Code

County: Cook

Telephone Number: (773) 941-4151 Fax # (773) 941-4591

HFS ID Number:

Date of Initial License for Current Owners: 05/15/1990

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

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

In the event there are further questions about this report, please contact:
Name: Ralph Storino, Dir. of Fiscal Mgmt Telephone Number: (773) 941-4151 ext. 216
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 07/01/2024 to 06/30/2025 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) 09/26/2025 (Date)
(Type or Print Name) Gerard S. Beagles
(Title) CEO / President

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () 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

Facility Name & ID Number

Garden Center Services

0036103

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	5,294							5,294	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,294							5,294	14

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

96.69%

D. How many bed reserve days during this year were paid by the Department?

130 (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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 05 / 15 / 1990

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

YES ☒ Date 05/15/1990 NO ☐

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

YES ☐ NO ☒ If YES, enter certified beds. number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 07/2024-06/2025 Fiscal Year: 07/01/2024-06/30/2025

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

Facility Name & ID Number Garden Center Services # 0036103 Report Period Beginning: 07/01/2024 Ending: 06/30/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	52,839	3,372		56,211		56,211		56,211			1
2	Food Purchase		48,086		48,086		48,086		48,086			2
3	Housekeeping	23,961	3,259		27,220		27,220		27,220			3
4	Laundry	18,184	2,444		20,628		20,628		20,628			4
5	Heat and Other Utilities			20,129	20,129		20,129		20,129			5
6	Maintenance	29,097	48,649	2,850	80,596		80,596		80,596			6
7	Other (specify):*			33,681	33,681		33,681		33,681			7
8	TOTAL General Services	124,081	105,810	56,660	286,551		286,551		286,551			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	596,997	20,551	2,564	620,112		620,112		620,112			10
10a	Therapy											10a
11	Activities		11,952		11,952		11,952		11,952			11
12	Social Services	67,656	9,610		77,266		77,266		77,266			12
13	CNA Training	9,602			9,602		9,602		9,602			13
14	Program Transportation		7,639		7,639		7,639		7,639			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	674,255	49,752	2,564	726,571		726,571		726,571			16
	C. General Administration											
17	Administrative	54,923			54,923		54,923		54,923			17
18	Directors Fees											18
19	Professional Services			18,349	18,349		18,349		18,349			19
20	Dues, Fees, Subscriptions & Promotions			4,511	4,511		4,511		4,511			20
21	Clerical & General Office Expenses	32,519	3,041	10,751	46,311		46,311		46,311			21
22	Employee Benefits & Payroll Taxes			165,003	165,003		165,003		165,003			22
23	Inservice Training & Education											23
24	Travel and Seminar			363	363		363		363			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,388	36,388		36,388		36,388			26
27	Other (specify):*											27
28	TOTAL General Administration	87,442	3,041	235,365	325,848		325,848		325,848			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	885,778	158,603	294,589	1,338,970		1,338,970		1,338,970			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			29,642	29,642		29,642		29,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,725	7,725		7,725		7,725			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			37,367	37,367		37,367		37,367			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			68,932	68,932		68,932		68,932			42
43	Other (specify):* Day Program Costs			363,630	363,630		363,630		363,630			43
44	TOTAL Special Cost Centers			432,562	432,562		432,562		432,562			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	885,778	158,603	764,518	1,808,899		1,808,899		1,808,899			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (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

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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[illegible]

VII. RELATED PARTIES

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

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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

STATE OF ILLINOIS

Ownership Listing-2

Garden Center Services

ID# 0036103

Report Period Beginning:	07/01/2024
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Ending: 06/30/2025

-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.

Operator/Licensee

Building Co.

**Management
Co./Home Office**

Ownership

Ownership

Ownership

	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
76	N/A							76
77								77
78								78
79								79
80								80
81								81
82								82
83								83
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148								148
149								149
150								150

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 6/30/2025

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CIBC Bank USA		X	ICF/DD	\$3,124.00	06/20/23	\$ 159,301	\$ 101,795	06/20/2028	0.0650	\$ 7,725	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,124.00		\$ 159,301	\$ 101,795			\$ 7,725	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 159,301	\$ 101,795			\$ 7,725	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	Exempt	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.)				\$	Exempt	2
3. Under or (over) accrual (line 2 minus line 1).				\$	#VALUE!	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.				\$		6
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.				\$	#VALUE!	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020		9			
	2021		10			
	2022		11			
	2023		12			
	2024		13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Garden Center Services COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036103

CONTACT PERSON REGARDING THIS REPORT Ralph Storino, Director of Fiscal Management

TELEPHONE (773) 941-4151 ext 216 FAX #: (773) 941-4591

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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 19-32-418-005-0000	8345 S. Austin Ave, Burbank,IL,6045	\$ Tax Exempt	\$
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 X 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 providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,355 B. General Construction Type: Exterior Brick Frame Ordinary Number of Stories One

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		10,000	1990	\$ 94,000	1
2					2
3	TOTALS	10,000		\$ 94,000	3

Facility Name & ID Number Garden Center Services

0036103

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	15		1990	1990	\$ 510,755	\$	31.5	\$	\$	\$ 510,755	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building			1993	2,912		31.5			2,912	9
10	Hot Water Heater			1996	6,272	199	31.5	199		5,870	10
11	Lot Repaving			1999	20,000		10			20,000	11
12	Kitchen Cabinetry, Flooring, Lighting			2010	14,350	957	15	957		13,873	12
13	Kichen Door			2010	5,000	333	15	333		4,832	13
14	Kitchen Electric Upgrade			2010	450	30	15	30		435	14
15	Kitchen Plumbing			2010	540	36	15	36		522	15
16	Building Roof			2011	21,900	1,460	15	1,460		21,170	16
17	ADA Bathroom Shower			2011	5,928		10			5,928	17
18	Three Exterior Doors			2012	4,201	280	15	280		3,501	18
19	Hot Water Heater			2013	2,862	191	15	191		2,195	19
20	American Standard Furnace			2014	1,900	127	15	127		1,458	20
21	Fire System Compressor			2014	1,901	127	15	127		1,458	21
22	Sewer Basin Outlet Line			2015	2,395	159	5	159		1,517	22
23	Hot Water Inducer Motor			2016	537	36	15	36		341	23
24	Living Room and Hallways Floors			2017	8,001	533	15	533		4,532	24
25	Heater Blower Motor			2018	560	40	7	40		560	25
26	Water Pump			2018	775	55	7	55		775	26
27	Laundry Room-Cabinet/Countertop remode			2018	6,491	433	15	433		3,243	27
28	Laundry Room-Plumbing Line Upgrade			2018	650	43	15	43		327	28
29	Five Heating/HVAC Units			2019	21,040	1,403	15	1,403		9,119	29
30	Front Door			2019	4,321	288	15	288		1,872	30
31	Bedroom Floor			2019	1,100	157	7	157		1,021	31
32	Parking Lot Addition			2020	1,315	87	15	87		483	32
33	Sprinkler Head Replacements			2020	15,500	1,033	5	1,033		5,682	33
34	Building Awnnig			2021	12,950	863	15	863		3,884	34
35	Sprinkler Head Replacements			2021	6,000	400	15	400		1,800	35
36	Back Door			2022	6,146	410	15	410		1,435	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Electrical 240 Volt Circuit	2022	\$ 1,600	\$ 107	15	\$ 107	\$	\$ 373	37
38	Generac Automatic Back Up Generator	2025	113,295	3,777	15	3,777		3,777	38
39	Roof Replacement	2025	31,920	1,064	15	1,064		1,064	39
40	Gutter Replacement	2025	7,425	248	15	248		248	40
41	East ADA Bathroom Remodel	2025	26,710	890	15	890		890	41
42	West ADA Bathroom Remodel	2025	23,310	777	15	777		777	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 891,012	\$ 16,542		\$ 16,542	\$	\$ 638,629	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 40,080	\$ 5,832	\$ 5,832	\$		\$ 25,530	71
72	Current Year Purchases	5,547	396	396			396	72
73	Fully Depreciated Assets	5,681					5,681	73
74								74
75	TOTALS	\$ 51,308	\$ 6,228	\$ 6,228	\$		\$ 31,607	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	ICF/DD	Chrysler Town and Country	2015	\$ 21,207	\$	\$	\$		\$ 21,207	76
77	ICF/DD	Chrysler T&C Transmission	2022	3,816	763	763			2,671	77
78	ICF/DD	Chrysler Pacifica	2025	61,092	6,109	6,109			6,109	78
79										79
80	TOTALS			\$ 86,115	\$ 6,872	\$ 6,872	\$		\$ 29,987	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)	\$ 1,122,435	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,642	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)	\$ 700,223	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

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

C. Vehicle Rental (See instructions.)

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

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	\$

* 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

☒

☐

☐

120

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)		9,602		9,602
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,602	\$	\$ 9,602
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,602			

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	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(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.

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

12345678										
	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
	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.

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	\$ 2,559,391	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,000)	694,493		3
4	Supply Inventory (priced at)	22,868		4
5	Short-Term Investments	994,825		5
6	Prepaid Insurance	125,591		6
7	Other Prepaid Expenses	44,633		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposits	3,230		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,445,031	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	729,376		13
14	Buildings, at Historical Cost	5,537,178		14
15	Leasehold Improvements, at Historical Cost	1,272,923		15
16	Equipment, at Historical Cost	1,344,498		16
17	Accumulated Depreciation (book methods)	(4,100,831)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,783,144	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,228,175	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 156,788	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	11,493		29
30	Accrued Salaries Payable	160,703		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,272		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	234,993		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Revenue	9,940		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 604,189	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,373,634		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)	\$ 1,373,634	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,977,823	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,250,352	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,228,175	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,072,186	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,072,186	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(296,758)	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) <u>Net results from Non-ICF Programs</u>	474,924	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 178,166	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)	\$ 7,250,352	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Garden Center Services

0036103

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 1,202,613	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,202,613	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	4,915	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)	\$ 4,915	23
	D. Non-Operating Revenue		
24	Contributions	2,725	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,725	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Revenue	301,888	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 301,888	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,512,141	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	286,551	31
32	Health Care	726,571	32
33	General Administration	325,848	33
	B. Capital Expense		
34	Ownership	37,367	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,932	36
	D. Other Expenses (specify):		
37	Day Program Costs	363,630	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,808,899	40
41	Income before Income Taxes (line 30 minus line 40)**	(296,758)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (296,758)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 946,503.00	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	256,110.00	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)	\$ 1,202,613	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,276	1,387	\$ 63,098	\$ 45.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,925	2,150	52,839	24.58	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	827	1,155	29,097	25.19	17
18	Housekeepers	1,082	1,216	23,961	19.70	18
19	Laundry	797	896	18,184	20.29	19
20	Administrator	214	250	23,124	92.50	20
21	Assistant Administrator	203	237	16,250	68.57	21
22	Other Administrative	210	239	15,549	65.06	22
23	Office Manager	251	278	10,731	38.60	23
24	Clerical	686	763	21,788	28.56	24
25	Vocational Instruction					25
26	Academic Instruction	281	312	9,602	30.78	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1,570	1,725	67,656	39.22	28
29	Resident Services Coordinator	991	1,126	47,194	41.91	29
30	Habilitation Aides (DD Homes)	20,163	22,167	481,918	21.74	30
31	Medical Records	201	227	4,787	21.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	30,677	34,128	\$ 885,778 *	\$ 25.95	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	49	2,564	10,Col. 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 2,564		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Gerard S. Beagles	CEO/President	0	\$ 23,124
Cindy Haworth	Chief Operating Officer	0	16,250
Ralph Storino	Dir of Fiscal Mgmt	0	15,549
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,923
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Cherry Bekaert LLC	Auditor	\$	2,803
James Absher	IT Consultant		438
Stephen Beagles	IT Consultant		796
Ryan Kirk	IT System Admin		10,402
ADP Workforce	Payroll Service		2,495
Principal Financial	Retirement Trust Fund		677
Shannon Benaitis	DD Services Consultant		546
Chugg	Disaster Planning		192
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 18,349
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	25,373
Unemployment Compensation Insurance			
FICA Taxes			66,167
Employee Health Insurance			69,738
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Disabilty Insurance			3,725
TOTAL (agree to Schedule V, line 22, col.8)			\$ 165,003
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	4		220
Association Dues (total from pg 22, #4)			4,126
Physicals			12
Reference Materials			153
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,511
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			363
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	363

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>1,740</u> |
| <u>Other, please specify Costco/Moss/Infinitect/IPP</u> | <u>2,386</u> |
| | <u>4,126</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|-------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | |
| <u>Other, please specify Costco/Moss/Infinitect/IPP</u> | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>1,740</u> |
| <u>Other, please specify Costco/Moss/Infinitect/IPP</u> | <u>2,386</u> |
| | <u>4,126</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 3,418 Line 10-2
- (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. \$ 68,932
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? Yes
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: Cherry Bekaert LLC (Currently In Progress)
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

2025 State of Illinois
Department of Healthcare and Family Services
Financial and Statistical Report for
Long-Term Care Facilities

Garden Center Services
8345 S. Austin Avenue Burbank, Illinois 60459

Facility ID Number : 0036103

Attachment for Page 4, Line 43 Column 3

Day Program Costs:

Salaries	\$	233,922
Payroll Benefits		52,055
Consultants and Related		15,092
Consumables		10,958
Occupancy		33,087
Transportation		11,896
Miscellaneous		6,620
	\$	<u>363,630</u>

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Garden Center Services
8345 S. Austin Avenue Burbank, Illinois 60459

Facility ID Number : 0036103

Garden Center Services Board of Directors

<u>Name</u>	<u>Title</u>	<u>Provides Services to ICF Facility?</u>	<u>Type ?</u>	<u>Transactions with ICF Facility?</u>	<u>Type?</u>	<u>Ownership in business transacting with ICF?</u>	<u>Type?</u>
Kathleen Akin	Board Member	No	N/A	No	N/A	No	N/A
Lisa Beemsterboer	Board Member	No	N/A	No	N/A	No	N/A
Shannon Benaitis	Secretary	No	N/A	No	N/A	No	N/A
John Considine	Board Member	No	N/A	No	N/A	No	N/A
Mary Gill	Board Member	No	N/A	No	N/A	No	N/A
Chris Grunow	Vice- Chair	No	N/A	No	N/A	No	N/A
Mary Ann Lema	Treasurer	No	N/A	No	N/A	No	N/A
Cindy Malloy	Board Member	No	N/A	No	N/A	No	N/A
Kari Riordan	Board Member	No	N/A	No	N/A	No	N/A
Jenny Wojcik	Chair	No	N/A	No	N/A	No	N/A

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Garden Center Services
8345 S. Austin Avenue Burbank, Illinois 60459

Facility ID Number : 0036103

Detail for Page 3, Line 7, Column 3
General Service- Other

Waste	\$	8,490
Security System		11,916
Consumer Personal Allowances		13,275
Total	\$	<u>33,681</u>

Detail for Page 3, Line 24, Column 3
General Administration- In-State Travel

<u>Employee Name</u>	<u>Title</u>	<u>Function</u>	<u>Cost</u>
Gerard Beagles	CEO/ President	Administrator	363
		Total	<u>\$ 363</u>