		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: 0037721

Facility Name: GROUP HOME 6

Address: 320 BACHMAN (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

Telephone Number: (618) 466-0367 **Fax #** (618) 466-3652

HFS ID Number:

Date of Initial License for Current Owners: 02/21/1992

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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)	(Date)
	(Type or Print Name)	CRYSTAL OFFICER
	(Title)	CEO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	DANIEL PHIPPS PRINCIPAL
	(Firm Name & Address)	SCHEFFEL BOYLE 106 W COUNTY ROAD, JERSEYVILLE, IL 62052
	(Telephone)	(618) 498-6841 Fax # (618) 498-6842

In the event there are further questions about this report, please contact:
Name: CRYSTAL OFFICER Telephone Number: (618) 466-0367
Email Address:

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 GROUP HOME 6 # 0037721 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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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 Medicaid Primary	MMAI Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,229							5,229	13
14	TOTALS	5,229							5,229	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 89.54%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/21/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/21/1992 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2025 Fiscal Year: 06/30/2025

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

Facility Name & ID Number GROUP HOME 6 # 0037721 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	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											1
2	Food Purchase		33,456		33,456		33,456		33,456			2
3	Housekeeping		8,008	853	8,861		8,861		8,861			3
4	Laundry											4
5	Heat and Other Utilities			20,099	20,099		20,099		20,099			5
6	Maintenance	27,301	3,427	18,666	49,394		49,394		49,394			6
7	Other (specify):* SECURITY			4,812	4,812		4,812		4,812			7
8	TOTAL General Services	27,301	44,891	44,430	116,622		116,622		116,622			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	411,874	8,112	14,752	434,738	(28,940)	405,798		405,798			10
10a	Therapy											10a
11	Activities	5,081	319	226	5,626		5,626		5,626			11
12	Social Services											12
13	CNA Training	6,307			6,307	29,327	35,634		35,634			13
14	Program Transportation	3,215			3,215		3,215		3,215			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	426,477	8,431	14,978	449,886	387	450,273		450,273			16
	C. General Administration											
17	Administrative	39,455	5,294	26,263	71,012	1,033	72,045		72,045			17
18	Directors Fees											18
19	Professional Services			72,963	72,963		72,963	(7,610)	65,353			19
20	Dues, Fees, Subscriptions & Promotions			9,699	9,699		9,699		9,699			20
21	Clerical & General Office Expenses	61,065	15,791	10,784	87,640		87,640		87,640			21
22	Employee Benefits & Payroll Taxes			132,186	132,186		132,186		132,186			22
23	Inservice Training & Education			469	469	(38)	431		431			23
24	Travel and Seminar			3,605	3,605	(2,982)	623		623			24
25	Other Admin. Staff Transportation			68	68		68		68			25
26	Insurance-Prop.Liab.Malpractice			31,631	31,631		31,631		31,631			26
27	Other (specify):* FUNDRAISING	22,320		1,790	24,110	1,600	25,710	(25,710)				27
28	TOTAL General Administration	122,840	21,085	289,458	433,383	(387)	432,996	(33,320)	399,676			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	576,618	74,407	348,866	999,891		999,891	(33,320)	966,571			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 GROUP HOME 6 #0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,535	25,535		25,535		25,535			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,036	12,036		12,036	(12,036)				32
33	Real Estate Taxes			29	29		29	(29)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS			1,237	1,237		1,237		1,237			36
37	TOTAL Ownership			38,837	38,837		38,837	(12,065)	26,772			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	619		390	1,009		1,009		1,009			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,290	57,290		57,290		57,290			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	619		57,680	58,299		58,299		58,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	577,237	74,407	445,383	1,097,027		1,097,027	(45,385)	1,051,642			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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(11,780)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(174)	32		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	(82)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,610)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,710)	27		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)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,385)		$	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))**	$ (45,385)		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

STATE OF ILLINOIS

GROUP HOME 6

ID# 0037721

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

	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	REAL ESTATE TAXES (ALLOCATED TO GH6)	(29)	33	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**	(29)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(7,610)	0	0	0	0	0	0	0	0	0	0	(7,610)	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):*	(25,710)	0	0	0	0	0	0	0	0	0	0	(25,710)	27
28	**TOTAL General Administration**	(33,320)	0	0	0	0	0	0	0	0	0	0	(33,320)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,320)	0	0	0	0	0	0	0	0	0	0	(33,320)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(12,036)	0	0	0	0	0	0	0	0	0	0	(12,036)	32
33	Real Estate Taxes	(29)	0	0	0	0	0	0	0	0	0	0	(29)	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**	(12,065)	0	0	0	0	0	0	0	0	0	0	(12,065)	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)**	(45,385)	0	0	0	0	0	0	0	0	0	0	(45,385)	45

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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
		BEVERLY FARM FOUNDATION	GODFREY			
		GROUP HOME #1	GODFREY			
		GROUP HOME #2	GODFREY			
		GROUP HOME #3	GODFREY			
		GROUP HOME #4	GODFREY			
		GROUP HOME #5	GODFREY			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

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

1 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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 [X] NO

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

1 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

GROUP HOME 6

ID# 0037721

Report Period Beginning: 07/01/2024

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.

	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	JIM		PARDIKES	LAKE IN THE H	IL	0.00000	0.00000	0.00000	1
2	SHARON		BYERS	LEE'S SUMMIT	MO	0.00000	0.00000	0.00000	2
3	NEVILLE		BILIMORIA	CHICAGO	IL	0.00000	0.00000	0.00000	3
4	BONNI		BURNS-SCHUETTE	ST. LOUIS	MO	0.00000	0.00000	0.00000	4
5	EMILY		FRIEND	SHORT HILLS	NJ	0.00000	0.00000	0.00000	5
6	ZACHARY		YODER	ALTON	IL	0.00000	0.00000	0.00000	6
7	BRIAN		ROSE	JACKSONVILLI	FL	0.00000	0.00000	0.00000	7
8	MOLLY		MILLIS	CHICAGO	IL	0.00000	0.00000	0.00000	8
9	MARK		SOFTY	PINEHURST	NC	0.00000	0.00000	0.00000	9
10	CHARLENE		SPICELAND	AMELIA ISLAN	FL	0.00000	0.00000	0.00000	10
11									11
12									12
13									13
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73									73
74									74
75									75

STATE OF ILLINOIS

Ownership Listing-2

GROUP HOME 6

ID# 0037721

Report Period Beginning: 07/01/2024

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.

	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
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141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	BOARD OF DIRECTORS	BOD	BOD	0.00	NONE	7	0.00		$ 0	N/A	1
2	(SEE OWNERSHIP-1)										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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BEVERLY FARM FOUNDATION &
Street Address: GROUP HOMES #1, #2, #3, #4, & #5
City / State / Zip Code: GODFREY, IL 62035
Phone Number: (618) 466-0367
Fax Number: (618) 466-3652

	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	2-2	FOOD COSTS	RESIDENT COUNT	3,190	9	$ 2,662	$	189	$ 158	1
2	3-2	OSHA/PANDEMIC SUPPLIES	RESIDENT COUNT	3,190	9	986		188	58	2
3	3-3	JANITOR SERVICE	RESIDENT COUNT	3,190	9	14,342		190	853	3
4	5-3	HEAT AND OTHER UTILITIES	RESIDENT COUNT	3,190	9	19,032		180	1,074	4
5	6-2	MAINTENANCE SUPPLIES	RESIDENT COUNT	3,190	9	32,526		178	1,820	5
6	6-3	MAINTENANCE-OTHER	RESIDENT COUNT	3,190	9	234,223		88	6,464	6
7	7-3	SECURITY/SAFETY	RESIDENT COUNT	3,190	9	80,942		190	4,812	7
8	10-2	NURSING AND MEDICAL SUPI	RESIDENT COUNT	3,190	9	52,402		48	791	8
9	10-3	CONTRACT NURSING	RESIDENT COUNT	3,190	9	848,862		41	10,848	9
10	11-2	ACTIVITIES SUPPLIES	RESIDENT COUNT	3,190	9	3,360		190	200	10
11	11-3	ACTIVITIES OTHER	RESIDENT COUNT	3,190	9	2,971		190	177	11
12	17-2	ADMINISTRATIVE-SUPPLIES	RESIDENT COUNT	3,190	9	62,681		189	3,723	12
13	17-3	ADMINISTRATIVE-OTHER	RESIDENT COUNT	3,190	9	359,738		183	20,634	13
14	19-3	LEGAL & ACCOUNTING	RESIDENT COUNT	3,190	9	1,227,274		190	72,963	14
15	20-3	DUES/SUBS/ADVERTISING	RESIDENT COUNT	3,190	9	186,408		159	9,309	15
16	21-2	SOFTWARE UPGRADES/SUPPI	RESIDENT COUNT	3,190	9	237,713		188	14,031	16
17	21-3	OUTSIDE ADMIN SERVICES	RESIDENT COUNT	3,190	9	186,012		185	10,769	17
18	22-3	EMPLOYEE BENEFITS	RESIDENT COUNT	3,190	9	1,240,121		130	50,654	18
19	23-3	MEETINGS/INSERVICE	RESIDENT COUNT	3,190	9	6,634		189	394	19
20	24-3	TRAVEL & SEMINAR	RESIDENT COUNT	3,190	9	43,153		188	2,548	20
21	25-3	TRANSPORTATION COSTS	RESIDENT COUNT	3,190	9	1,144		190	68	21
22	26-3	INSURANCE	RESIDENT COUNT	3,190	9	545,800		185	31,631	22
23	27-3	FUNDRAISING	RESIDENT COUNT	3,190	9	30,108		190	1,790	23
24	32-3	INTEREST	RESIDENT COUNT	3,190	9	213,096		180	12,036	24
25	TOTALS					$ 5,632,190	$		$ 257,805	25

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BEVERLY FARM FOUNDATION &
Street Address: GROUP HOMES #1, #2, #3, #4, & #5
City / State / Zip Code: GODFREY, IL 62035
Phone Number: (618) 466-0367
Fax Number: (618) 466-3652

	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	33-3	REAL ESTATE TAXES	RESIDENT COUNT	3,190	9	$ 492	$	188	$ 29	1
2	36-3	MORTGAGE INSURANCE	RESIDENT COUNT	3,190	9	20,811		190	1,237	2
3	39-3	ANCILLARY SERVICES	RESIDENT COUNT	3,190	9	30,492		41	390	3
4	6-1	MAINTENANCE SALARIES	RESIDENT COUNT	3,190	9	459,699	459,699	189	27,301	4
5	10-1	NURSING AND MEDICAL REC	RESIDENT COUNT	3,190	9	1,832,417	1,832,417	50	28,736	5
6	11-1	ACTIVITIES SALARIES	RESIDENT COUNT	3,190	9	85,439	85,439	190	5,081	6
7	13-1	CNA TRAINING SALARIES	RESIDENT COUNT	3,190	9	106,803	106,803	188	6,307	7
8	14-1	TRANSPORTATION SALARIES	RESIDENT COUNT	3,190	9	251,134	251,134	41	3,215	8
9	17-1	ADMINISTRATIVE SALARIES	RESIDENT COUNT	3,190	9	343,514	343,514	220	23,729	9
10	21-1	PERSONNEL-ACCOUNTING SA	RESIDENT COUNT	3,190	9	1,070,732	1,070,732	180	60,335	10
11	27-1	FUNDRAISING/DEVELOPMEN	RESIDENT COUNT	3,190	9	375,437	375,437	190	22,320	11
12	39-1	ANCILLARY SALARIES	RESIDENT COUNT	3,190	9	48,456	48,456	41	619	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					$ 4,625,426	$ 4,573,631		$ 179,299	25

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	GERSHMAN MORTGAGE		X	REFINANCE BONDS	$2,946.00	09/09/13	$ 460,755	$ 218,707	08/01/32	0.0417	$ 11,431	1
2	AMORTIZATION OF DEBT COST		X								349	2
3												3
4												4
5												5
	Working Capital											
6	WELLS FARGO		X	WORKING CAPITAL		05/13/19			N/A	VARIABLE		6
7												7
8												8
9	TOTAL Facility Related				$2,946.00		$ 460,755	$ 218,707			$ 11,780	9
	B. Non-Facility Related*											
10	FINANCE LEASES		X		$592.00	7/1/22	26,862	13,471			174	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$592.00		$ 26,862	$ 13,471			$ 174	14
15	TOTALS (line 9+line14)						$ 487,617	$ 232,178			$ 11,954	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 1,237 Line # 36-3

* 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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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.**	$ 29	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).		$ (29)	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.		$ (29)	7

Assessed Value from Real Estate Tax Bill:	2024	433	8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024	29	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 GROUP HOME 6 COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0037721

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,112 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories ONE

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

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

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

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

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

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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	10,000		$ 5,000	1
2					2
3	TOTALS	10,000		$ 5,000	3

Facility Name & ID Number GROUP HOME 6 # 0037721 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 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	16			1992	$ 317,200	$ 7,930	40	$ 7,930	$	$ 264,395	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1992	6,822	171	40	171		5,543	9
10	BUILDING IMPROVEMENTS			1995	188		5			188	10
11	BUILDING IMPROVEMENTS			2002	853		10			853	11
12	BUILDING IMPROVEMENTS			2003	9,626		10			9,626	12
13	BUILDING IMPROVEMENTS			2005	2,523		10			2,522	13
14	BUILDING IMPROVEMENTS			2006	3,459		10			3,459	14
15	BUILDING IMPROVEMENTS			2007	1,599		10			1,599	15
16	BUILDING IMPROVEMENTS			2008	6,910		5			6,910	16
17	BUILDING IMPROVEMENTS			2013	5,106		10			5,106	17
18	BUILDING IMPROVEMENTS			2015	4,332		5			4,331	18
19	BUILDING IMPROVEMENTS			2016	10,900	1,090	10	1,090		9,810	19
20	BUILDING IMPROVEMENTS			2017	29,798	1,888	VAR	1,888		15,076	20
21	BUILDING IMPROVEMENTS			2018	4,495	449	10	449		2,960	21
22	BUILDING IMPROVEMENTS			2019	25,207	1,232	VAR	1,232		7,311	22
23	BUILDING IMPROVEMENTS			2021	3,297	330	10	330		1,347	23
24	HVAC			2022	5,500	550	10	550		1,925	24
25	4 BATHROOMS AND BEDROOMS FLOORING			2022	24,544	2,454	10	2,454		6,136	25
26	B UNIT DOOR			2024	2,980	298	10	298		447	26
27	NEW GUTTERS			2023	5,648	565	10	565		847	27
28	ONYX SHOWER			2025	8,795	439	10	439		439	28
29	BUILDING IMPROVEMENTS-ALLOCATED			1996	55,609	1,390	VAR	1,390		39,622	29
30	BUILDING IMPROVEMENTS-ALLOCATED			1997	860		VAR			860	30
31	BUILDING IMPROVEMENTS-ALLOCATED			1998	942		15			942	31
32	BUILDING IMRPOVEMENTS-ALLOCATED			1999	52		20			52	32
33	BUILDING IMPROVEMENTS-ALLOCATED			2000	27		20			27	33
34	BUILDING IMPROVEMENTS-ALLOCATED			2004	63		10			63	34
35	BUILDING IMPROVEMENTS-ALLOCATED			2012	239		VAR			237	35
36	BUILDING IMPROVEMENTS-ALLOCATED			2013	2,784		VAR			2,785	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 GROUP HOME 6 # 0037721 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 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	BUILDING IMPROVEMENTS-ALLOCATED	2014	$ 885	$	10	$	$	$ 885	37
38	BUILDING IMPROVEMENTS-ALLOCATED	2015	1,411	77	VAR	77		1,411	38
39	BUILDING IMPROVEMENTS-ALLOCATED	2016	6,514	439	20	439		4,936	39
40	BUILDING IMPROVEMENTS-ALLOCATED	2017	28,011	1,189	VAR	1,189		9,315	40
41	BUILDING IMPROVEMENTS-ALLOCATED	2018	2,917	249	VAR	249		2,085	41
42	BUILDING IMPROVEMENTS-ALLOCATED	2019	1,953	193	10	193		1,228	42
43	BUILDING IMPROVEMENTS-ALLOCATED	2020	177	18	10	18		87	43
44	BUILDING IMPROVEMENTS-ALLOCATED	2021	655	66	10	66		229	44
45	ADMIN - NEW HVAC-ALLOCATED	2022	350	35	10	35		123	45
46	ADMIN - DOORS - ALLOCATED	2023	326	33	10	33		49	46
47	OUTSIDE LIGHT FIXTURES - ALLOCATED	2024	182	18	10	18		27	47
48	ADMIN - CONCRETE PAD - ALLOCATED	2025	544	18	10	18		17	48
49	TRANSPORTATION - FIRE PANEL - ALLOCATED	2025	504	25	10	25		24	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)		$ 584,787	$ 21,146		$ 21,146	$	$ 415,834	70

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

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	$ 32,717	$ 3,614	$ 3,614	$	5-10	$ 22,428	71
72	Current Year Purchases	6,527	653	653		5-10	653	72
73	Fully Depreciated Assets	87,904	47	47		5-10	87,904	73
74								74
75	TOTALS	$ 127,148	$ 4,314	$ 4,314	$		$ 110,985	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	SEE ATTACHED SCHEDULE			$ 43,259	$ 75	$ 75	$	5-10	$ 42,996	76
77										77
78										78
79										79
80	TOTALS			$ 43,259	$ 75	$ 75	$		$ 42,996	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)	$ 760,194	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,535	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,535	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)	$ 569,815	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	ASPHALT - ALLOCATED	$ 2,055	92
93			93
94			94
95		$ 2,055	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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	85

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		401		401
3	Classroom Wages (a)		11,520		11,520
4	Clinical Wages (b)		13,600		13,600
5	In-House Trainer Wages (c)		9,695		9,695
6	Transportation				
7	Contractual Payments		418		418
8	CNA Competency Tests				
9	TOTALS	$	$ 35,634	$	$ 35,634
10	SUM OF line 9, col. 1 and 2 (e)	$ 35,634			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(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.

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	39-3	visits		2	198		2	198	5
6	Dental Care	39-1/39-3	visits	619	2	192		2	811	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			$ 619	4	$ 390	$	4	$ 1,009	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.

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2025 (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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,254,367		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,254,367	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	586,842		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	170,407		16
17	Accumulated Depreciation (book methods)	(569,815)		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)**	$ 192,434	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,446,801	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	218,707		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	FINANCE LEASES	13,471		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 232,178	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 232,178	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,214,623	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,446,801	$	48

*(See instructions.)

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,851,343	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,851,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	363,280	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 363,280	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)**	$ 2,214,623	24 *

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

Facility Name & ID Number GROUP HOME 6 # 0037721 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,072,814	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,072,814	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	242,227	24
25	Interest and Other Investment Income***	132,008	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 374,235	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	674	28
28a	GOVERNMENT GRANTS	12,584	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,258	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,460,307	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	116,622	31
32	Health Care	450,273	32
33	General Administration	432,996	33
	B. Capital Expense		
34	Ownership	38,837	34
	C. Ancillary Expense		
35	Special Cost Centers	1,009	35
36	Provider Participation Fee	57,290	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,097,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	363,280	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 363,280	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$	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		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)	$	56

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	23	27	$ 1,255	$ 46.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	145	168	7,324	43.60	3
4	Licensed Practical Nurses	225	264	10,699	40.53	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	117	127	2,330	18.35	9
10	Activity Assistants	107	126	2,751	21.83	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,207	1,327	27,301	20.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	311	311	15,726	50.57	20
21	Assistant Administrator					21
22	Other Administrative	600	660	39,866	60.40	22
23	Office Manager					23
24	Clerical	1,854	2,149	48,586	22.61	24
25	Vocational Instruction					25
26	Academic Instruction	183	205	6,307	30.77	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1	1	12	12.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,751	18,232	389,915	21.39	30
31	Medical Records	95	108	2,669	24.71	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	493	555	22,496	40.53	33
34	TOTAL (lines 1 - 33)	23,112	24,260	$ 577,237 *	$ 23.79	34

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

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				38
39	Pharmacist Consultant	11 MONTHS	884	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 884		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	10	$ 956	10-3	50
51	Licensed Practical Nurses	47	3,976	10-3	51
52	Certified Nurse Assistants/Aides	233	8,936	10-3	52
53	TOTAL (lines 50 - 52)	290	$ 13,868		53

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CRYSTAL OFFICER	CHIEF EXEC. OFFICER	0	$ 17,164
JARROD ECKARD	CONTROLLER	0	6,565
RACHEL LOLLIS	GROUP HOME ADMIN	0	15,726
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 39,455

B. Administrative - Other

Description	Amount
OUTSOURCING-PAYROLL/IT/FINANCE	$ 25,536
MISCELLANEOUS	727
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 26,263

C. Professional Services

Vendor/Payee	Type	Amount
SEE ENCLOSED WORKSHEET	LEGAL FEES	$ 23,359
SCHEFFEL BOYLE	ACCOUNTING & AUDITING	9,401
CHB ADVISORS	OUTSOURCED FINANCE	39,873
ALERUS FINANCIAL	401K INVESTMENT	12
ARCO CONSULTING SERVICES	CONSULTING SERVICES	297
ARMANINO ADVISORY LLC	TECHNOLOGY SERVICES	9
TAXBANDITS	1099 FILING	12
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 72,963

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,539
Unemployment Compensation Insurance	12,824
FICA Taxes	43,581
Employee Health Insurance	45,944
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
MISC EMPLOYEE BENEFITS	10,327
RETIREMENT	2,971
TOTAL (agree to Schedule V, line 22, col.8)	$ 132,186

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,052
Health Care Worker Background Check	
(Indicate # of checks performed 6)	248
Patient Background Checks 16	170
Association Dues (total from pg 22, #4)	1,315
DUES/SUBS/LICENSE FEES	2,439
PROMOTIONS	2,475
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,699

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
MEETINGS/SEMINARS/TRAVEL	623
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 623

**See instructions.

Facility Name & ID Number GROUP HOME 6 # 0037721 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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
IL HEALTHCARE ASSOCIATION (IHCA)	89
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	1,226
	1,315 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	
	Total

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

IL HEALTHCARE ASSOCIATION (IHCA)	89
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	1,226
	1,315 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 0 Line N/A

(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. $ 57,290
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. $ 0 Has any meal income been offset against related costs? NO 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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 92%
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? YES
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. $ 0

(13) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHEFFEL BOYLE

(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? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.

GROUP HOME 6 (#0037721)
PAGES 3 & 4, SCHEDULE V RECLASSIFICATIONS
JUNE 30, 2025

CNA TRAINING INCLUDED AS NURSING	$ 28,940	13
	(28,940)	10
FUNDRAISING INCLUDED AS MEETINGS/INSERVICE	$ 62	27
	(62)	23
FUNDRAISING INCLUDED AS TRAVEL/SEMINAR	$ 1,538	27
CNA TRAINING INCLUDED AS TRAVEL/SEMINAR	387	13
TUITION REIMBURSEMENT INCLUDED AS TRAVEL/ SEMINAR	1,033	17
MEETINGS/INSERVICE INCLUDED AS TRAVEL/SEMINAR	24	23
	(2,982)	24

GROUP HOME 6 (#0037721)
PAGE 10, SCHEDULE IX - REAL ESTATE TAXES
JUNE 30, 2025

REAL ESTATE TAXES ON PAGE 10 OF THE COST REPORT ARE ON LAND HELD FOR NON-CARE RELATED PURPOSES.

GROUP HOME #6 (#0037721)
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2025

Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
IDOT VAN #15	$ 2,218	$ -	$ -	$ 2,218
IDOT VAN #16	2,218	-	-	2,218
MAINT. #8 F350 TRUCK	1,329	-	-	1,329
TRUCK FOR MAINTENANCE	257	-	-	257
2006 CHRYSLER VAN #10	867	-	-	867
VANS-WHEELCHAIR STRAP	121	-	-	121
TRANSPORTATION VAN	1,804	-	-	1,804
TRANSPORTATION VAN	1,433	-	-	1,433
IDOT VAN	1,628	-	-	1,628
MAINTENANCE - TRUCK	1,703	-	-	1,703
SHOULDER HARNESSES	86	-	-	86
IDOT VAN	2,887	-	-	2,887
2010 CHRYSLER	1,574	-	-	1,574
MAINTENANCE TRUCK	276	-	-	276
4X4 CHEVY TRUCK	874	-	-	874
CHEVY C1500 SILVERADO	1,120	-	-	1,120
2008 MERCURY MARINER	861	-	-	861
FORD E250	2,045	-	-	2,045
FLEET REPAIRS	338	-	-	338
DUMP TRUCK REPAIRS	35	-	-	35
VAN SEAT REPAIR	219	-	-	219
VAN	2,844	-	-	2,844
1997 FORD PICKUP	294	-	-	294
MAINT-2010 F150 4X2	755	-	-	755
MAINT-2012 4X4 F-150	755	-	-	755
TRANSPORTATION-VAN #14 LIFT	288	-	-	288
TRANSPORTATION-VAN #6 LIFT	65	-	-	65
TRANSPORTATION-TURTLE TOP BUS	3,322	-	-	3,322
TRANSPORTATION-NEW VAN	1,268	-	-	1,268
TRANSPORTATION-NEW VAN	2,460	-	-	2,460
SECURITY VEHICLE 2018 FORD FUSION	1,149	-	-	1,149
2019 GRAND CARAVAN	1,169	-	-	1,169
2017 FORD TRANSIT VAN TRANSIT-350	1,675	-	-	1,675
2018 FORD E-350 WHEELCHAIR BUS	2,946	-	-	2,946
TRANSMISSION VAN 37	376	75	75	113
	$ 43,259	$ 75	$ 75	$ 42,996

GROUP HOME 6 (#0037721)
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2025

	1	2	3	4
SERVICE	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
DENTAL ASSISTANT	14	16	$ 619	38.69
TRANSPORTATION	158	177	3,215	18.16
DEVELOPMENT DIRECTOR	210	240	15,192	63.30
MARKETING MANAGER	111	122	3,470	28.44
	493	555	$ 22,496	

GROUP HOME 6 (#0037721)
OTHER REVENUE, PAGE 19, LINES 28 & LINE 29
JUNE 30, 2025

MISCELLANEOUS INCOME

REFUNDS, REIMBURSEMENTS, AND INSURANCE CLAIMS	$ 674
	$ 674

GOVERNMENT GRANTS

RECRUITMENT AND RETENTION PROGRAM - CDS	$ 12,584
	$ 12,584