

		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: 0055038

Facility Name: Grove of St Charles

Address: 611 Allen Lane St Charles 60174

County: Kane

Telephone Number: (630) 377-2211 Fax # (630) 377-4060

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2018

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: John Epperson Telephone Number: (312) 344-2883

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 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title) John Epperson Principal

(Firm Name & Address) Miller Cooper & Co., Ltd. 3 Parkway North, Suite 200, Deerfield IL 60015

(Telephone) (312) 344-2883 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 Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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				47		2,412	783	3,242	8
9	SNF/PED									9
10	ICF	8,148	13,276	3,255		3,307			27,986	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	8,148	13,276	3,255	47	3,307	2,412	783	31,228	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 71.30%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 10/01/2018

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		13,936	705,391	719,327		719,327	155	719,482			1
2	Food Purchase		1,474		1,474		1,474		1,474			2
3	Housekeeping		2,913	259,451	262,364		262,364	349	262,713			3
4	Laundry	39,991	22,167	80,108	142,266		142,266		142,266			4
5	Heat and Other Utilities			235,833	235,833		235,833	(16,550)	219,283			5
6	Maintenance	130,522	7,974	114,408	252,904		252,904	34,398	287,302			6
7	Other (specify):*							562	562			7
8	TOTAL General Services	170,513	48,464	1,395,191	1,614,168		1,614,168	18,914	1,633,082			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000	3,457	27,457			9
10	Nursing and Medical Records	2,357,843	99,877	1,262,825	3,720,545		3,720,545	59,193	3,779,738			10
10a	Therapy	195,755		7,500	203,255		203,255	1,568	204,823			10a
11	Activities	149,633	9,478	2,176	161,287		161,287	65	161,352			11
12	Social Services	123,911		4,045	127,956		127,956	1,281	129,237			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,809	9,809			15
16	TOTAL Health Care and Programs	2,827,142	109,355	1,300,546	4,237,043		4,237,043	75,373	4,312,416			16
	C. General Administration											
17	Administrative	134,878			134,878		134,878	29,308	164,186			17
18	Directors Fees											18
19	Professional Services			141,104	141,104		141,104	84,134	225,238			19
20	Dues, Fees, Subscriptions & Promotions			51,907	51,907		51,907	(26,006)	25,901			20
21	Clerical & General Office Expenses	314,342	2,369	456,735	773,446		773,446	(36,891)	736,555			21
22	Employee Benefits & Payroll Taxes			518,684	518,684		518,684		518,684			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,398	1,398		1,398	519	1,917			24
25	Other Admin. Staff Transportation							1,970	1,970			25
26	Insurance-Prop.Liab.Malpractice			151,298	151,298		151,298	4,428	155,726			26
27	Other (specify):*							17,974	17,974			27
28	TOTAL General Administration	449,220	2,369	1,321,126	1,772,715		1,772,715	75,436	1,848,151			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,446,875	160,188	4,016,863	7,623,926		7,623,926	169,723	7,793,649			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			255,377	255,377		255,377	(197,699)	57,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,036	20,036		20,036	392,513	412,549			32
33	Real Estate Taxes			113,527	113,527		113,527	916	114,443			33
34	Rent-Facility & Grounds			564,489	564,489		564,489	(554,706)	9,783			34
35	Rent-Equipment & Vehicles			8,695	8,695		8,695	919	9,614			35
36	Other (specify):*							35,532	35,532			36
37	TOTAL Ownership			962,124	962,124		962,124	(322,525)	639,599			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		291,216	721,319	1,012,535		1,012,535		1,012,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* Management fees			553,153	553,153		553,153		553,153			43
44	TOTAL Special Cost Centers		291,216	1,274,472	1,565,688		1,565,688		1,565,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,446,875	451,404	6,253,459	10,151,738		10,151,738	(152,802)	9,998,936			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	(17,192)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,706)	30		9
10	Interest and Other Investment Income	(761)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(26,483)	21		19
20	Contributions	(4,584)	21		20
21	Owner or Key-Man Insurance	(12,000)	20		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,946)	21		24
25	Fund Raising, Advertising and Promotional	(4,596)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(735,750)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (981,018)		\$	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)	346,148		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 346,148		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (634,870)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (10,440)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Expense	(553,153)		3
4	Bank Charges	(18,147)		4
5	Patient Personal Items	(413)		5
6	Sequestration Expense	(43,969)		6
7	Non-Allowable Legal	(689)		7
8	Building Co. - Asset Management Fees	(27,500)		8
9	Building Co. - Amortization	(35,532)		9
10	Building Co. - Professional Fees	(45,907)		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	(735,750)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	155	0	0	0	0	0	0	0	0	155	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	349	0	0	0	0	0	0	0	0	349	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(17,192)	0	362	280	0	0	0	0	0	0	0	(16,550)	5
6	Maintenance	0	27,500	6,628	352	(82)	0	0	0	0	0	0	34,398	6
7	Other (specify):*	0	0	562	0	0	0	0	0	0	0	0	562	7
8	TOTAL General Services	(17,192)	27,500	8,056	632	(82)	0	0	0	0	0	0	18,914	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,457	0	0	0	0	0	0	0	0	3,457	9
10	Nursing and Medical Records	0	0	59,718	0	0	(525)	0	0	0	0	0	59,193	10
10a	Therapy	0	0	1,568	0	0	0	0	0	0	0	0	1,568	10a
11	Activities	0	0	65	0	0	0	0	0	0	0	0	65	11
12	Social Services	0	0	1,281	0	0	0	0	0	0	0	0	1,281	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	9,809	0	0	0	0	0	0	0	0	9,809	15
16	TOTAL Health Care and Programs	0	0	75,898	0	0	(525)	0	0	0	0	0	75,373	16
	C. General Administration													
17	Administrative	0	0	29,308	0	0	0	0	0	0	0	0	29,308	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	45,907	41,643	28	0	0	(3,444)	0	0	0	0	84,134	19
20	Fees, Subscriptions & Promotions	(27,036)	0	1,030	0	0	0	0	0	0	0	0	(26,006)	20
21	Clerical & General Office Expenses	(197,013)	3,476	156,622	24	0	0	0	0	0	0	0	(36,891)	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	519	0	0	0	0	0	0	0	0	519	24
25	Other Admin. Staff Transportation	0	0	1,970	0	0	0	0	0	0	0	0	1,970	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,344	84	0	0	0	0	0	0	0	4,428	26
27	Other (specify):*	0	0	17,974	0	0	0	0	0	0	0	0	17,974	27
28	TOTAL General Administration	(224,049)	49,383	253,410	136	0	0	(3,444)	0	0	0	0	75,436	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(241,241)	76,883	337,364	768	(82)	(525)	(3,444)	0	0	0	0	169,723	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(13,706)	(185,223)	0	1,230	0	0	0	0	0	0	0	(197,699)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(761)	394,055	(1,554)	773	0	0	0	0	0	0	0	392,513	32
33	Real Estate Taxes	0	0	0	916	0	0	0	0	0	0	0	916	33
34	Rent-Facility & Grounds	0	(564,489)	9,783	0	0	0	0	0	0	0	0	(554,706)	34
35	Rent-Equipment & Vehicles	0	0	919	0	0	0	0	0	0	0	0	919	35
36	Other (specify):*	0	35,532	0	0	0	0	0	0	0	0	0	35,532	36
37	TOTAL Ownership	(14,467)	(320,125)	9,148	2,919	0	0	0	0	0	0	0	(322,525)	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)	(255,708)	(243,242)	346,512	3,687	(82)	(525)	(3,444)	0	0	0	0	(152,802)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership Listing-1		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 564,489	St. Charles Property Holdings, LLC		\$	(564,489)	1
2	V	33	Real Estate Taxes	113,527	St. Charles Property Holdings, LLC		113,527		2
3	V	32	Interest	20,036	St. Charles Property Holdings, LLC		414,091	394,055	3
4	V	21	Filing Fees		St. Charles Property Holdings, LLC		3,476	3,476	4
5	V	06	Asset Management Fees		St. Charles Property Holdings, LLC		27,500	27,500	5
6	V	30	Depreciation	255,377	St. Charles Property Holdings, LLC		70,154	(185,223)	6
7	V	36	Amortization		St. Charles Property Holdings, LLC		35,532	35,532	7
8	V	19	Professional fees		St. Charles Property Holdings, LLC		45,907	45,907	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 953,429			\$ 710,187	\$ * (243,242)	14

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

Facility Name & ID Number

Grove of St Charles

0055038

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	Astoria Place Living and Rehab	Chicago, IL	Bella Terra Streamwood	Streamwood, IL	St. Chalres Property Holdings LLC		Building Company	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	Legacy HC & Financial	Skokie	Home Office/Book	2
3	Avantara Aurora	Aurora, IL	Carlton at the Lake	Chicago, IL	CF St. Louis LLC	Skokie	Building Company	3
4	Avantara Chicago Ridge	Chicago Ridge, IL	Chalet Living and Rehab	Chicago, IL	ML Group Design & Interiors	Skokie	Asset Management	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	ReMED Services LLC	Skokie	Nursing Equipment	5
6	Avantara of Elgin	Elgin, IL	Glenview Terrace	Glenview, IL	Propay HR	Evanston	Payroll Processing	6
7	Avantara Evergreen Park	Evergreen Park, IL	Harmony Cedar Rapids	Cedar Rapids, IA				7
8	Avantara Groton	Groton, SD	Harmony Davenport	Davenport, IA				8
9	Avantara Huron	Huron, SD	Harmony Dubuque	Dubuque, IA				9
10	Avantara Lake Norden	Lake Norden, SD	Harmony Marshalltown	Marshalltown, IA				10
11	Avantara Lake Zurich	Lake Zurich, IL	Harmony Healthcare & Rehabilitation Center	Chicago, IL				11
12	Avantara Libertyville	Libertyville, IL	Harmony Palos	Palos Heights, IL				12
13	Avantara Lincoln Park	Chicago, IL	Harmony Utica Ridge	Davenport, IA				13
14	Avantara Long Grove	Long Grove, IL	Harmony Waterloo	Waterloo, IA				14
15	Avantara Milbank	Milbank, SD	Harmony West Des Moines	West Des Moines, IA				15
16	Avantara Mountain View	Rapid City, SD	Lakefront	Chicago, IL				16
17	Avantara North	Rapid City, SD	Peterson Park Health Care Center	Chicago, IL				17
18	Avantara Norton	Rapid City, SD	Grove at the Lake	Zion, IL				18
19	Avantara Palos Heights	Palos Heights, IL	Harmony House Care Center ICF	Waterloo, IA				19
20	Avantara Park Ridge	Park Ridge, IL	The Grove of Elmhurst	Elmhurst, IL				20
21	Avantara Pierre	Pierre, SD	The Grove of Evanston	Evanston, IL				21
22	Avantara Redfield	Redfield, SD	The Grove of Fox Valley	Aurora, IL				22
23	Avantara Saint Cloud	St. Cloud, MN	The Grove of La Grange Park	La Grange Park, IL				23
24	Avantara Watertown	Watertown, SD	The Grove of Northbrook	Northbrook, IL				24
25	Bella Terra Bloomingdale	Bloomingdale, IL	The Grove of Skokie	Skokie, IL				25
26	Bella Terra Elmhurst	Elmhurst, IL	Grove of St. Charles	St. Charles, IL				26
27	Bella Terra La Grange	La Grange, IL	Vistas Fox Valley	Aurora, IL				27
28	Bella Terra Lombard	Lombard, IL	Vistas of Lincoln Park	Chicago, IL				28
29	Bella Terra Morton Grove	Morton Grove, IL	Wellshire Morton Grove	Morton Grove, IL				29
30	Bella Terra Schaumburg	Schaumburg, IL	Warren Barr Buffalo Grove	Buffalo Grove, IL				30

Facility Name & ID Number

Grove of St Charles

0055038

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	Warren Barr Gold Coast	Chicago, IL	Nora Springs Care Center	Nora Springs, IA				1
2	Warren Barr Lieberman	Skokie, IL	Grandview Care Center	Oelwein, IA				2
3	Warren Barr Lincoln Park	Chicago, IL	Oelwein Healthcare Center	Oelwein, IA				3
4	Warren Barr North Shore	Highland Park, IL	Park View Care Center	Sac City, IA				4
5	Whitehall	Deerfield, IL	Manor House Care Center	Sigourney, IA				5
6	Warren Barr Orland Park	Orland Park, IL	Main Street Manor	Swea City, IA				6
7	Warren Barr South Loop	Chicago, IL	Harmony House Care Center SNF	Waterloo, IA				7
8	Wellshire Huron	Huron, SD	Northgate Care Center	Waukon, IA				8
9	Wellshire Park Place	Milbank, SD	Southfield Wellness Community	Webster City, IA				9
10	Warren Barr Oak Lawn	Oak Lawn, IL	Avantara Joliet	Joliet, IL				10
11	Rehab Center Of Allison	Allison, IA	Harmony Park Ridge	Park Ridge, IL				11
12	Maple Manor Village	Aplington, IA	Mulberry Place Independent & Assisted Living	Bloomfield, IA				12
13	Valley Vue Care Center	Armstrong, IA	Afton Oaks Independent & Assisted Living	Elma, IA				13
14	Willow Dale Wellness Village	Battle Creek, IA	Southfield Wellness Community Independent &	Webster City, IA				14
15	Rehab Center Of Belmont	Belmont, IA	Emerald Oaks Independent & Assisted Living	Emmetsburg, IA				15
16	Bloomfield Care Center	Bloomfield, IA	Eagle Ridge Assisted Living Apartments	Guttenberg, IA				16
17	Westview Care Center	Britt, IA	Cherry Ridge Independent & Assisted Living	Mount Vernon, IA				17
18	Oakwood Care Center	Clear Lake, IA	Mills Harbor Assisted Living Lake	Lake Mills, IA				18
19	Colonial Manor Of Elma	Elma, IA	Deer View Manor Independent & Assisted Living	Sigourney, IA				19
20	Emmetsburg Care Center	Emmetsburg, IA	Maple Manor Village Independent & Assisted Living	Aplington, IA				20
21	Concord Care Center	Garner, IA	Summit Heights	Nora Springs, IA				21
22	Guttenberg Care Center	Guttenberg, IA	Southercrest Manor II Assisted Living	Waukon, IA				22
23	Rehab Center Of Hampton	Hampton, IA	The Courtyard	West Des Moines, IA				23
24	Rehab Center Of Independence-West	Independence, IA	Park Place Independent & Assisted Living	Sac City, IA				24
25	Westview Of Indianola	Indianola, IA	Elm Springs	Arkansas, IA				25
26	Rehab Center Of Lisbon	Lisbon, IA	Belle Haven Independent & Assisted Living	Blemond, IA				26
27	Lake Mills Care Center	Lake Mills, IA	Leahy Grove Independent & Assisted Living	Hampton, IA				27
28	Heritage Health & Rehab Center	Cedar Rapids, IA	Indian Creek Independent & Assisted Living	Nevada, IA				28
29	Hallmark Care Center	Mt Vernon, IA	Spring Creek Independent & Assisted Living	Armstrong, IA				29
30	Rolling Green Village	Nevada, IA	Clark SNF	Clark St, IL				30

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	Elmbrook SNF	Elmhurst, IL						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

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	1	<u>Dietary</u>	\$	<u>Legacy Healthcare Financial Services</u>		\$ 155	\$ 155	15
16	V	3	<u>Housekeeping</u>		<u>Legacy Healthcare Financial Services</u>		349	349	16
17	V	5	<u>Heat and other Utilities</u>		<u>Legacy Healthcare Financial Services</u>		362	362	17
18	V	6	<u>Maintenece</u>		<u>Legacy Healthcare Financial Services</u>		6,628	6,628	18
19	V	7	<u>Other (specify):*Employee Benefits</u>		<u>Legacy Healthcare Financial Services</u>		562	562	19
20	V	9	<u>Medical Director</u>		<u>Legacy Healthcare Financial Services</u>		3,457	3,457	20
21	V	10	<u>Nursing and Medical Records</u>		<u>Legacy Healthcare Financial Services</u>		59,718	59,718	21
22	V	10A	<u>Therapy</u>		<u>Legacy Healthcare Financial Services</u>		1,568	1,568	22
23	V	11	<u>Activities</u>		<u>Legacy Healthcare Financial Services</u>		65	65	23
24	V	12	<u>Social Services</u>		<u>Legacy Healthcare Financial Services</u>		1,281	1,281	24
25	V	15	<u>Other (specify):*Employee Benefits</u>		<u>Legacy Healthcare Financial Services</u>		9,809	9,809	25
26	V	17	<u>Administrative</u>		<u>Legacy Healthcare Financial Services</u>		29,308	29,308	26
27	V	19	<u>Professional Services</u>		<u>Legacy Healthcare Financial Services</u>		41,643	41,643	27
28	V	20	<u>Dues, Fees, Subscriptions & Promotions</u>		<u>Legacy Healthcare Financial Services</u>		1,030	1,030	28
29	V	21	<u>Clerical & General Office Expenses</u>		<u>Legacy Healthcare Financial Services</u>		156,622	156,622	29
30	V	24	<u>Travel and Seminar</u>		<u>Legacy Healthcare Financial Services</u>		519	519	30
31	V	25	<u>Other Admin. Staff Transportation</u>		<u>Legacy Healthcare Financial Services</u>		1,970	1,970	31
32	V	26	<u>Insurance-Prop.Liab.Malpractice</u>		<u>Legacy Healthcare Financial Services</u>		4,344	4,344	32
33	V	27	<u>Other (specify):* Employee Benefits</u>		<u>Legacy Healthcare Financial Services</u>		17,974	17,974	33
34	V	32	<u>Interest</u>		<u>Legacy Healthcare Financial Services</u>		(1,554)	(1,554)	34
35	V	34	<u>Rent-Facility & Grounds</u>		<u>Legacy Healthcare Financial Services</u>		9,783	9,783	35
36	V	35	<u>Equipment Rental</u>		<u>Legacy Healthcare Financial Services</u>		113	113	36
37	V	35	<u>Auto Rental</u>		<u>Legacy Healthcare Financial Services</u>		806	806	37
38	V								38
39	Total			\$			\$ 346,512	\$ * 346,512	39

* 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	5	Utilities	\$			\$ 280	\$ 280	15
16	V	6	Repairs and Maintenance				352	352	16
17	V	19	Real Estate Appraisal Fee				28	28	17
18	V	20	Professional Fees				0		18
19	V	21	Office Expense				24	24	19
20	V	26	Insurance				84	84	20
21	V	30	Depreciation				1,230	1,230	21
22	V	32	Interest Expense				773	773	22
23	V	33	Real Estate Taxes				916	916	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			\$			\$ 3,687	\$ * 3,687	39

* 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	6	Maintenance	\$ 6,000	ML Group Design & Development		\$ 5,918	\$ (82)	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			\$ 6,000			\$ 5,918	\$ * (82)	39

* 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	10	Medical Supplies	\$ 7,756	ReMED Services		\$ 7,231	\$ (525)	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			\$ 7,756			\$ 7,231	\$ * (525)	39

* 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	19	Payroll Service	\$ 15,118	ProPay HR LLC		\$ 11,674	\$ (3,444)	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			\$ 15,118			\$ 11,674	\$ * (3,444)	39

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

STATE OF ILLINOIS				Ownership Listing-1						
Grove of St Charles		ID# 0055038								
Report Period Beginning:		01/01/2025		Legacy Healthcare FS						
Ending:		12/31/2025		St. Charles Property Holdings, LLC						
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management						
-Owners of companies must be listed instead of company names.				Operator/Licensee		Building Co.	Co./Home Office			
-Names of trust beneficiaries must be listed.				Ownership		Ownership	Ownership			
First Name		M.I.	Last Name	Place of Residence	City	State	Percentage	Percentage	Percentage	
1	GPN Family Trust								1	
2	Beneficiary								2	
3	Rivka		Rajchenbach		Chicago	IL	10.62500	12.00000	3	
4	Bella		Rajchenbach		Chicago	IL	10.62500	12.00000	4	
5	Yitzchok		Rajchenbach		Chicago	IL	10.62500	12.00000	5	
6	Ziskind		Rajchenbach		Chicago	IL	10.62500	12.00000	6	
7									7	
8	Oakway Operations LLC								8	
9	Daniel		Garden		Chicago	IL	4.90000		9	
10	Rebecca		Garden		Chicago	IL	2.60000		10	
11	Mordechay		Ninio		Chicago	IL	4.90000		11	
12	Sherie		Ninio		Chicago	IL	2.60000		12	
13									13	
14	Doros Generation Trust								14	
15	Beneficiary								15	
16	Ahuva		Shabat		Lincolnwood	IL	8.50000	2.40000	16	
17	Eliana		Shabat		Lincolnwood	IL	8.50000	2.40000	17	
18	Ayalet		Shabat		Lincolnwood	IL	8.50000	2.40000	18	
19	Ashira		Shabat		Lincolnwood	IL	8.50000	2.40000	19	
20	Leora		Shabat		Lincolnwood	IL	8.50000	2.40000	20	
21									21	
22	Legacy Healthcare Financial Service								22	
23	Chaim		Rajchenbach		Chicago	IL		13.40000	50.00000	23
24	Menachem		Shabat		Lincolnwood	IL		10.00000	50.00000	24
25									25	
26	Yoseph		Rajchenbach		Chicago	IL		3.40000		26
27	Avrohom		Rajchenbach		Chicago	IL		3.40000		27
28	Moshe		Rajchenbach		Chicago	IL		3.40000		28
29									29	
30	Larkin Ave Investors II (6.40% Holder)								30	
31	Yitzhak		Rosenblum		Lincolnwood	IL		0.42700		31
32	Mordechay		Ninio		Chicago	IL		0.42700		32
33	Daniel		Garden		Chicago	IL		0.42700		33
34	Ben		Shibe		Chicago	IL		0.42700		34
35	Shai		Berdugo		Skokie	IL		0.42700		35
36	Chaim		Rajchenbach		Chicago	IL		1.70700		36
37	Menachem		Shabat		Lincolnwood	IL		1.70700		37
38	Mordechai		Kaplan		Chicago	IL		0.42700		38
39	Eli		Davis		Skokie	IL		0.42700		39
40									40	
41									41	
42									42	
43									43	
44									44	
45									45	
46									46	
47									47	
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72									72	
73									73	
74									74	
75									75	

VII. RELATED PARTIES (continued)

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

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

	1 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

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Legacy Healthcare Financial Services
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Census Days / Direct Allocation	121	121	\$ 17,417	\$ 188,860		\$ 155	1
2	3	Housekeeping	Census Days / Direct Allocation	121	121	39,313			349	2
3	5	Heat and other Utilities	Census Days / Direct Allocation	121	121	40,732			362	3
4	6	Maintenece	Census Days / Direct Allocation	121	121	1,086,339			6,628	4
5	7	Other (specify):*Employee Benefit	Census Days / Direct Allocation	121	121	115,823			562	5
6	9	Medical Director	Census Days / Direct Allocation	121	121	389,400	1,007,031		3,457	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation	121	121	7,945,861	12,523,114		59,718	7
8	10A	Therapy	Census Days / Direct Allocation	121	121	176,684	152,483		1,568	8
9	11	Activities	Census Days / Direct Allocation	121	121	7,371			65	9
10	12	Social Services	Census Days / Direct Allocation	121	121	144,309	144,309		1,281	10
11	15	Other (specify):*Employee Benefit	Census Days / Direct Allocation	121	121	1,241,625			9,809	11
12	17	Administrative	Census Days / Direct Allocation	121	121	5,453,317			29,308	12
13	19	Professional Services	Census Days / Direct Allocation	121	121	4,691,102	5,453,317		41,643	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation	121	121	116,052			1,030	14
15	21	Clerical & General Office Expense	Census Days / Direct Allocation	121	121	20,639,396	19,821,678		156,622	15
16	24	Travel and Seminar	Census Days / Direct Allocation	121	121	58,495			519	16
17	25	Other Admin. Staff Transportatio	Census Days / Direct Allocation	121	121	221,955			1,970	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation	121	121	489,395			4,344	18
19	27	Other (specify):* Employee Benefi	Census Days / Direct Allocation	121	121	2,646,369			17,974	19
20	32	Interest	Census Days / Direct Allocation	121	121	(175,042)			(1,554)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation	121	121	1,102,008			9,783	21
22	35	Equipment Rental	Census Days / Direct Allocation	121	121	12,712			113	22
23	35	Auto Rental	Census Days / Direct Allocation	121	121	90,802			806	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 346,512	25

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Census Days	3,517,851	121	\$ 31,540	\$	31,228	\$ 280	1
2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680		31,228	352	2
3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155		31,228	28	3
4	20	Professional Fees	Census Days	3,517,851	121			31,228		4
5	21	Office Expense	Census Days	3,517,851	121	2,733		31,228	24	5
6	26	Insurance	Census Days	3,517,851	121	9,443		31,228	84	6
7	30	Depreciation	Census Days	3,517,851	121	138,584		31,228	1,230	7
8	32	Interest Expense	Census Days	3,517,851	121	87,057		31,228	773	8
9	33	Real Estate Taxes	Census Days	3,517,851	121	103,201		31,228	916	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 415,393	\$		\$ 3,687	25

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ML Group Design and Development
Street Address 3424 Oakton St.
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
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	6	Maintenance	Direct		\$	\$		\$ 5,918	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 5,918	25

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ReMED Services LLC
Street Address 3424 Oakton Street, Suite 102
City / State / Zip Code Skokie, IL
Phone Number (847) 440-2600
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	10	Medical Supplies	Direct		\$	\$		\$ 7,756	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 7,756	25

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization ProPay HR LLC
Street Address 2201 W. Main St.
City / State / Zip Code Evanston, IL 60202
Phone Number (847) 905-3268
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			\$	\$		\$ 15,118	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 15,118	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		X	Mortgage Payable			\$	5,508,720			\$	414,091	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	CIBC Bank		X	Line of Credit - Shared				(25,000)				19,298	6	
7	IPFS Corporation		X	Prepaid Insurance - Interest Only								738	7	
8													8	
9	TOTAL Facility Related						\$	5,483,720				\$	434,127	9
	B. Non-Facility Related*													
10	Interest Income		X									19,298	10	
11	Interest Income - Bldg Co.		X									(8,813)	11	
12	Allocated from CF St. Louis	X										773	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	11,258	14
15	TOTALS (line 9+line14)						\$	5,483,720				\$	445,385	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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	Grove of St Charles	COUNTY	Kane
---------------	---------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT John Epperson

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

2

C. Does the Operating Entity?

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

None.

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

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

X

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

N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

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	Facility			\$304,000	1
2	Allocated from CF St. Lous LLC			785	2
3	TOTALS			\$304,785	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2018	1978	\$ 3,336,000	\$ 70,154	35	\$ 95,314	\$ 25,160	\$ 762,514	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2018	22,567		20	1,128	1,128	9,027	9
10	Various			2019	91,741		20	4,587	4,587	32,109	10
11	Various			2020	1,821,712		20	91,086	91,086	546,514	11
12	Various			2021	27,833		20	1,392	1,392	6,958	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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,299,853	\$ 70,154		\$ 193,507	\$ 123,353	\$ 1,357,122	70

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

XL 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	
1	Totals from Page 12A, Carried Forward		\$ 5,299,853	\$ 70,154			\$ 193,507	\$ 123,353	\$ 1,357,122	1
2	Current year depreciation			227,055				(227,055)		2
3						20				3
4	Install 5 Door Closes-Kitchen,Med Rm,Patio & Fire Doors (\$3,641	2022	3,542			20	177	177	708	4
5	Railings Install (\$4,500)	2022	4,378			20	219	219	876	5
6	Repair Entrance Main Doors & Trims, Bedroom Doors & Trims (\$	2022	8,270			20	414	414	1,654	6
7	Repair Mammoth Units On Roof - New Metal (\$2,793)	2022	2,717			20	136	136	543	7
8	Rtu #5 Compressor - Replace Motor Protector (\$4,559)	2022	4,436			20	222	222	887	8
9	Install 2 New Cameras In Basement & 9 Cameras On 1St Floor (	2023	9,310			20	466	466	1,397	9
10	Replace Boiler Vent,Install High Wind Cap,Storm Collar & Flashi	2023	3,351			20	168	168	503	10
11	Replace #4 Blower Motor & Adjusted 1-4 Temp Controls (\$2688)	2023	2,601			20	130	130	390	11
12	Repair 3 Leaks On Circuit #2 Of Mammoth Unit (\$3328)	2023	3,220			20	161	161	483	12
13	Pothole and Asphalt clean up and addition	2024	4,200			20	210	210	420	13
14	Fire Door rebuild, roof and exhaust fan repair	2024	2,850			20	143	143	285	14
15	HVAC rooftop	2024	218,238			20	10,912	10,912	21,824	15
16	Kitchen tiling remodel	2024	4,496			20	225	225	450	16
17	Plumping and Piping replacements and Kitchen/Laudry water line	2024	3,975			20	199	199	398	17
18	Mill & Pave	2025	6,050			20	303	303	303	18
19	Kitchen unit repair	2025	3,553			20	178	178	178	19
20	Fire door, roof top exhaust fans, motors and wirings repair	2025	2,675			20	134	134	134	20
21	Installation of new storm basin and repair of collapsed drain line	2025	8,756			20	438	438	438	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 5,596,471	\$ 297,209			\$ 208,338	\$ (88,871)	\$ 1,388,991	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,596,471	\$ 297,209		\$ 208,338	\$ (88,871)	\$ 1,388,991	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,596,471	\$ 297,209		\$ 208,338	\$ (88,871)	\$ 1,388,991	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,596,471	\$ 297,209		\$ 208,338	\$ (88,871)	\$ 1,388,991	1
2									2
3	Related Party								3
4	Buildings:								4
5	Allocated from CF St. Louis, LLC	2016	4,225	84	35	121	37	1,207	5
6									6
7	Leasehold Improvements:								7
8	Allocated from CF St. Louis, LLC	2016	58,568	403	20	2,928	2,525	29,284	8
9	Allocated from CF St. Louis, LLC	2017	1,359	35	20	68	33	612	9
10	Allocated from CF St. Louis, LLC	2019	12,321	316	20	616	300	4,312	10
11	Allocated from CF St. Louis, LLC	2020	648	17	20	32	15	194	11
12	Allocated from CF St. Louis, LLC	2021	2,301	59	20	115	56	575	12
13	Allocated from CF St. Louis, LLC	2022	3,803	98	20	190	92	761	13
14	Allocated from CF St. Louis, LLC	2023	530	14	20	27	13	80	14
15									15
16	Allocated from Legacy HC	2018	70		20	4	4	28	16
17	Allocated from Legacy HC	2020	53		20	3	3	16	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,680,349	\$ 298,235		\$ 212,441	\$ (85,794)	\$ 1,426,060	34

**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	\$ 977,795	\$ 26,233	\$ 97,782	\$ 71,549	10	\$ 710,010	71
72	Current Year Purchases	28,250	2,286	2,825	539	10	2,825	72
73	Fully Depreciated Assets	2,353					2,353	73
74								74
75	TOTALS	\$ 1,008,398	\$ 28,519	\$ 100,607	\$ 72,088		\$ 715,188	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,993,532	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 326,754	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,048	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,706)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,141,247	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.

Grove of St. Charles
0055038
Moveable Equipment Schedule
01/01/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Grove of St. Charles	613,927	26,036	61,393	35,357	455,676
St. Charles Property Holdings, LLC	360,000	-	36,000	36,000	252,000
Allocated from Legacy HC	29	-	5	5	9
Allocated from CF St. Louis, LLC	3,839	197	384	187	2,325
Total	977,795	26,233	97,782	71,549	710,010

Line 29: Current Year

Grove of St. Charles	28,250	2,286	2,825	539	2,825
St. Charles Property Holdings, LLC	-	-	-	-	-
Allocated from Legacy HC	-	-	-	-	-
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	28,250	2,286	2,825	539	2,825

Line 30: Fully Depreciated

Grove of St. Charles	-	-	-	-	-
St. Charles Property Holdings, LLC	-	-	-	-	-
Allocated from Legacy HC	2,353	-	-	-	2,353
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	2,353	-	-	-	2,353

Total (Should tie to page 13)

Grove of St. Charles	642,177	28,322	64,218	35,896	458,501
St. Charles Property Holdings, LLC	360,000	-	36,000	36,000	252,000
Allocated from Legacy HC	2,382	-	5	5	2,362
Allocated from CF St. Louis, LLC	3,839	197	384	187	2,325
	-	-	-	-	-
Total	1,008,398	28,519	100,607	72,088	715,188

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Legacy HC				9,783			5
6								6
7	TOTAL				\$ 9,783			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 X
16. Rental Amount for movable equipment: \$ 8,808 Description: See Supplemental Schedule Attached
(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	Allocated from Legacy HC		\$	\$ 806	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 806	21

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

SUPPLEMENTAL SCHEDULE OF EQUIPMNT RENTAL		12/31/2025
	Description	Amount
16A	Copiers	6,355
16B	Air Fresheners	2,340
16C	Allocation from Legacy HC	113
16D		
16E		
16F		
16G		
16 H		
16I		
16J		
		8,808
	Allocated from Legacy HC	

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 256,206	\$		\$ 256,206	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			153,303			153,303	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			242,362			242,362	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts				200,542		200,542	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					69,448	90,674		160,122	13
14	TOTAL			\$		\$ 721,319	\$ 291,216		\$ 1,012,535	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.

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

Special Services - Supplies (Column 6 - Other)			Amount	Special Services - Salary (Column 3 - Staff)		Amount
13A	Supplies - Medical	39-2	71,661	13U		
13B	Supplies - G-Tube	39-2	4,162	13V		
13C	Oxygen	39-2	14,851	13W		
13D				13X		
13E				13Y		
13F				13Z		
13G						
13 H						
13I						
13J						
			90,674			
Special Services - Outside (Column 5 - Other)						
13K	Durable Medical Equipment	39-3	20,955			
13L	Oxygen Equipment Rental	39-3	636			
13M	Radiology	39-3	13,352			
13N	Laboratory	39-3	34,505			
13O						
13P						
13Q						
13R						
13S						
13T			69,448			

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 157,928	\$ 279,619	1
2	Cash-Patient Deposits	447	447	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,516,938	1,516,938	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,394	10,394	6
7	Other Prepaid Expenses	2,725	2,725	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	89,971	144,192	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,778,403	\$ 1,954,315	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,820	318,820	13
14	Buildings, at Historical Cost		2,736,000	14
15	Leasehold Improvements, at Historical Cost	2,265,288	2,265,288	15
16	Equipment, at Historical Cost	299,356	1,259,356	16
17	Accumulated Depreciation (book methods)	(1,297,996)	(2,176,839)	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):	(96,799)	1,771,334	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,184,669	\$ 6,173,959	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,963,072	\$ 8,128,274	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 679,632	\$ 679,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,810	51,810	28
29	Short-Term Notes Payable	(25,000)	(25,000)	29
30	Accrued Salaries Payable	134,527	134,527	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,857	2,857	31
32	Accrued Real Estate Taxes(Sch.IX-B)		112,831	32
33	Accrued Interest Payable	645	29,788	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	65,073	65,073	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 909,544	\$ 1,051,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,508,720	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,300,572	2,300,573	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,300,572	\$ 7,809,293	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,210,116	\$ 8,860,811	46
47	TOTAL EQUITY(page 18, line 24)	\$ (247,044)	\$ (732,537)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,963,072	\$ 8,128,274	48

*(See instructions.)

Supplemental Schedule Of Other Assets And Liabilities As of 12/31/2024

Other Current Assets		Amount	Amount	Other Current Liabilities		Amount	Amount
09A	Refund	41,749.00	41,749.00	36A	Prepaid - Legal Fees	5,000	5,000
09B	Exchange	(3,001)	(3,001)	36B	Accrued Accounting Fees	12,607	12,607
09C	Insurance Refund Exchange	(8,238)	(8,238)	36C	Accrued Monthly Assessment Fee	70,447	70,447
09D	Accounts Receivable - Quality Incentive	(231,549)	(231,549)	36D	Due to/from Medicare	(36,383)	(36,383)
09E	C.N.A. Tenure Program	291,010	291,010	36E	Due to BCBS	13,402	13,402
09F	Bad Debt Part A - MMAI	-	-	36F			
09G	CapEx Reserve Fund - A		-	36G			
09H	Principal Sinking Fund- CapEx		54,221	36H			
09I	Deferred Rent Receivable		-	36I			
09J	Accrued R/E Tax Reimb		(112,831)	36J			
		89,971	31,361			65,073	65,073
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	Security Deposit	9,300	9,300	43A	Due To/From Propco	(1,852,153)	(1,852,153)
23B	Due To/From - Grove Of St. Charles & Management Co	7,782	7,782	43B	Due To/From Prior Owner	1,581	1,581
23C	Due To/From - Grove Of St. Charles & Avantara Elgi	(128,537)	(128,537)	43C	Due To/From Members - Entities	(450,000)	(450,000)
23D	Accrued Management Fees Entities	14,656	14,656	43D			
23E	Due to/From		239,633	43E			
23F	Due to/from HPE		-	43F			
23G	Due to/from Larkin (Elgin) Property Holdings		(240,721)	43G			
23H	Due to/from Cascade Capital Group LLC		(45,903)	43H			
23I	Due to/from OpCo		1,861,248	43I			
23J	See next page		53,876	43J			
		(96,799)	1,771,334			(2,300,572)	(2,300,572)

Supplemental Schedule Of Other Assets And Liabilities			As of 12/31/2024				
Other Current Assets		Amount	Amount	Other Current Liabilities		Amount	Amount
09A				36A			
09B				36B			
09C				36C			
09D				36D			
09E				36E			
09F				36F			
09G				36G			
09H				36H			
09I				36I			
09J				36J			
		-	-			-	-
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	Due to/from Operator		-	43A			
23B	Due to/from Title Company		-	43B			
23C	Good Faith Deposit		-	43C			
23D	Financing Fees		63,595	43D			
23E	A/A Financing Fee		(9,719)	43E			
23F				43F			
23G				43G			
23H				43H			
23I				43I			
23J		-	53,876	43J		-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (709,186)	1
2	Restatements (describe):		2
3	Equity Restatement - PY		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (709,186)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	534,963	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	(72,821)	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)	\$ 462,142	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)	\$ (247,044)	24 *

* This must agree with page 17, line 47.

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,070,578	1
2	Discounts and Allowances for all Levels	(4,618,032)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,452,546	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,414,974	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,414,974	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	203,890	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,130	20
21	Other Medical Services	113,709	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 325,729	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	761	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 761	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quality Incentive, Discounts, Rebates and Misc. Income	66,557	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 66,557	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,260,567	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,614,168	31
32	Health Care	4,237,043	32
33	General Administration	1,772,715	33
	B. Capital Expense		
34	Ownership	962,124	34
	C. Ancillary Expense		
35	Special Cost Centers	1,565,688	35
36	Provider Participation Fee	573,866	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,725,604	40
41	Income before Income Taxes (line 30 minus line 40)**	534,963	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 534,963	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,221,191.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,619,113.00	45
46	MMAI-Medicaid is the Primary Payer	887,332.00	46
47	MMAI-Medicare is the Primary Payer	6,904.00	47
48	Private Pay	1,091,872.00	48
49	Medicare Part A	354,311.00	49
50	Other-(specify) Insurance	271,823.00	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)	\$ 8,452,546	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	1,832	2,096	\$ 163,610	\$ 78.06	1
2	Assistant Director of Nursing	1,912	2,080	106,382	51.15	2
3	Registered Nurses	24,023	27,108	1,237,470	45.65	3
4	Licensed Practical Nurses	7,742	8,708	303,739	34.88	4
5	CNAs & Orderlies	18,895	21,094	502,858	23.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,146	6,714	195,755	29.16	8
9	Activity Director	1,912	2,080	56,446	27.14	9
10	Activity Assistants	4,953	5,473	93,187	17.03	10
11	Social Service Workers	3,836	4,220	123,911	29.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,485	3,970	130,522	32.88	17
18	Housekeepers					18
19	Laundry	1,763	2,079	39,991	19.24	19
20	Administrator	1,920	2,080	134,878	64.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,831	10,704	314,342	29.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,907	2,107	43,784	20.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,157	100,513	\$ 3,446,875 *	\$ 34.29	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 705,391	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	660	10-03	38
39	Pharmacist Consultant	Monthly	15,487	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,176	11-03	44
45	Social Service Consultant	Monthly	2,295	12-03	45
46	Other(specify) Payroll Consultant	Monthly	15,118	19-03	46
47	Psychiatric Consultant	Monthly	1,750	12-03	47
48	Dialysis Consultant	Monthly	81,228	10-03	48
49	TOTAL (lines 35 - 48)		\$ 848,105		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,062	\$ 397,562		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	25,269	755,967		52
53	TOTAL (lines 50 - 52)	30,331	\$ 1,153,529		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Grove of St Charles

0055038Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Niki Gandhi

Administrator

0

\$ 134,878

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 134,878

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

See Attached

Legal

\$ 8,074

People Powered LLC

48,234

Legacy Healthcare Financial Services

19,919

HCCI

15,957

Propay HR LLC

13,762

Achieve Accreditation LLC

9,440

Onyx Procurement Solutions, LLC

6,100

Apploi Corp

5,861

AR Proactive Workflows

5,364

Compliagent

2,654

PR Paycor

1,356

See Supplemental Schedule

4,382

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$

141,104

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 110,858

Unemployment Compensation Insurance

15,227

FICA Taxes

245,666

Employee Health Insurance

67,146

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401K Expense

23,422

Other Employee Benefits

33,479

Voluntary Benefit Contribution

15,740

Employee Physical Exams

7,146

TOTAL (agree to Schedule V, line 22, col.8)

\$ 518,684

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

\$ 1,990

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed 63)

631

Patient Background Checks

493

Association Dues (total from pg 22, #4)

20,880

Other Dues & Subscriptions

4,770

Licenses & Permits

2,113

Allocation from Legacy Healthcare

1,030

Less: Public Relations Expense

()

PAC and Lobbying payments

(10,440)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 25,901

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,398

Allocation from Legacy HC

519

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,917

* Attach copy of IMRF notifications

**See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,		\$	TOTAL (agree to Sch. V,	\$
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners			\$ 1,000			\$	Out-of-State Travel	\$
Sogolytics, LLC			670					
Optum			517					
Huron Consulting Group, LLC			504				In-State Travel	
CertiSurv, LLC			500					
Aida Healthcare			496					
Collaborative Healthcare Urgency Group			314					
Ravi Fernando			300				Seminar Expense	
TAP Innovations, LLC			66					
Language Line Services, Inc.			17					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 4,382				(agree to Sch. V,	
							line 24, col. 8)	
							TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

GROVE OF ST. CHARLES
0055038
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
1/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	45	45	-
2/8/2025	580063	Corporation Service Company	Statutory Representation	104	-	104
3/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	320	320	-
4/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	320	320	-
5/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	767	767	-
6/9/2025	580063	Corporation Service Company	Matter Management	198	-	198
6/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	415	415	-
7/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	154	154	-
8/6/2025	580063	Meyer Magence	General Counsel	88	-	88
8/25/2025	580063	Law Hesselbaum	Regulatory Compliance	85	-	85
8/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	202	202	-
9/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	60	60	-
10/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	700	700	-
11/21/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	38	-	38
11/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	110	110	-
12/17/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	90	-	90
12/23/2025	580063	Meyer Magence	General Counsel	88	-	88
12/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	288	288	-
12/31/2025	580063	CIBC Bank	RLOC retainage fee	1,500	1,500	-
12/31/2025	580063	CIBC Bank	RLOC retainage fee	2,505	2,505	-
						-
						-
						-
						-
						-
						-
						-
						-
Total				8,074	7,385	689

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
HEALTH CARE COUNCIL OF IL (HCCI)	10,440
	10,440 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.

HEALTH CARE COUNCIL OF IL (HCCI)	10,440
	10,440 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	20,880
	20,880 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	34,071	Line	10
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- (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.

\$	573,866
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This amount is to be recorded on line 42 of Schedule V.
- (8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$		Has any meal income been offset against related costs?	N/A	Indicate the amount.	\$	
----	--	--	-----	----------------------	----	--
- (12) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

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

100% LN1

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?

N/A

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

N/A

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

No

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

\$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name: N/A
- (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.