

		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: 0019976

Facility Name: The H J Vonderlieth Lvg Ctr

Address: 1120 North Topper Dr Mount Pulaski 62548

NumberCityZip Code

County: Logan

Telephone Number: (217) 792-3218 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

xx

VOLUNTARY,NON-PROFIT

xx

Charitable Corp.

Trust

IRS Exemption Code 501 C 3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name: Daniel CurryTelephone Number: 309-823-7164Email 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) Daniel Curry

(Title) EVP & CFO

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number The H J Vonderlieth Lvg Ctr # 0019976 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 _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	1,192	3,025	742	27	13,400	1,827	729	20,942	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,192	3,025	742	27	13,400	1,827	729	20,942	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 63.75%

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 1973

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 90

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The H J Vonderlieth Lvg Ctr # 0019976 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	296,085	16,892	6,751	319,728		319,728		319,728			1
2	Food Purchase		172,013		172,013		172,013		172,013			2
3	Housekeeping	143,209	31,153		174,362		174,362		174,362			3
4	Laundry	54,350	17,396		71,746		71,746		71,746			4
5	Heat and Other Utilities			139,241	139,241		139,241		139,241			5
6	Maintenance	153,061	119,926	44,819	317,806		317,806		317,806			6
7	Other (specify):*											7
8	TOTAL General Services	646,705	357,380	190,811	1,194,896		1,194,896		1,194,896			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,153,706	102,988	237,160	2,493,854	175,033	2,668,887		2,668,887			10
10a	Therapy		108,339	9,248	117,587	(112,743)	4,844		4,844			10a
11	Activities	126,253	2,778		129,031		129,031		129,031			11
12	Social Services	48,250		3,525	51,775		51,775		51,775			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Employee Scholarship	5,664			5,664		5,664		5,664			15
16	TOTAL Health Care and Programs	2,333,873	214,105	273,933	2,821,911	62,290	2,884,201		2,884,201			16
	C. General Administration											
17	Administrative	144,584			144,584		144,584		144,584			17
18	Directors Fees											18
19	Professional Services			368,464	368,464		368,464	(986)	367,478			19
20	Dues, Fees, Subscriptions & Promotions			392,948	392,948	(346,964)	45,984	(12,875)	33,109			20
21	Clerical & General Office Expenses	340,988	37,554	122,898	501,440	(179,877)	321,563		321,563			21
22	Employee Benefits & Payroll Taxes			633,650	633,650		633,650		633,650			22
23	Inservice Training & Education			927	927		927		927			23
24	Travel and Seminar			1,951	1,951		1,951		1,951			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			305,435	305,435		305,435		305,435			26
27	Other (specify):* Lost Resident Items			22,121	22,121		22,121	(22,000)	121			27
28	TOTAL General Administration	485,572	37,554	1,848,394	2,371,520	(526,841)	1,844,679	(35,861)	1,808,818			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,466,150	609,039	2,313,138	6,388,327	(464,551)	5,923,776	(35,861)	5,887,915			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			254,820	254,820		254,820		254,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			42,339	42,339		42,339	(24,000)	18,339			35
36	Other (specify):*											36
37	TOTAL Ownership			297,159	297,159		297,159	(24,000)	273,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			395,290	395,290	117,587	512,877		512,877			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					346,964	346,964		346,964			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			395,290	395,290	464,551	859,841		859,841			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,466,150	609,039	3,005,587	7,080,776		7,080,776	(59,861)	7,020,915			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(24,000)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(8,096)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(986)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,000)			24
25	Fund Raising, Advertising and Promotional	(4,779)			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 Real estate taxes paid on non resident prop				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,861)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (59,861)		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	xx		8,500	10a	42
43	Prescription Drugs	xx		108,339	10a	43
44	Hospital Services	xx		748	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 117,587		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (7,830)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(22,000)	27	11
12		0	33	12
13		0	27	13
14		3,051	20	14
15		(8,096)	20	15
16		(24,000)	35	16
17		0	24	17
18		(986)	19	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	(59,861)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors List Attached		None		Vonderlieth Apartmen	Mt. Pulaski IL	Independent Living
(Not for profit Board-No individual ownership)				Vonderlieth Trust	Mt. Pulaski IL	Support

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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 Members are not compensated								\$		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 2/31/2025

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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

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	None						\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	VLC Trust-Interest free	xx		Cash Flow				2,917,848				6
7												7
8												8
9	TOTAL Facility Related						\$	2,917,848			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	2,917,848			\$	15

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

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

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

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

The H J Vonderlieth Lvg Ctr

COUNTY

Logan

FACILITY IDPH LICENSE NUMBER

0019976

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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. None		\$	\$
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 providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (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? [xx] (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).
Vonderlieth Apartments - 25 unit independent living apartments located adjacent to (but not physically connected) the Vonderlieth Living Center.

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number The H J Vonderlieth Lvg Ctr

0019976

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	90			1973	\$ 1,628,148	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1979 Improvements		1979	11,345						9
10	1981 Improvements		1981	1,209						10
11	1982 Improvements		1982	1,175						11
12	1984 Improvements		1984	6,809						12
13	1985 Improvements		1985	14,582						13
14	1986 Improvements		1986	44,534						14
15	1987 Improvements		1987	29,649						15
16	1990 Improvements		1990	985						16
17	1991 Improvements		1991	155,036						17
18	1992 Improvements		1992	26,901						18
19	1988 Improvements		1988	437						19
20	1983 Improvements		1983	954						20
21	1993 Improvements		1993	10,736						21
22	1994 Improvements		1994	5,683						22
23	1995 Improvements		1995	335,750						23
24	1996 Improvements		1996	9,161						24
25	1997 Improvements		1997	1,691						25
26	1998 Improvements		1998	837,524						26
27	1999 Improvements		1999	1,020						27
28	2000 Improvements		2000	33,449						28
29	2001 Improvements		2001	83,680						29
30	2002 Improvements		2002	103,212						30
31	2003 Improvements		2003	35,768						31
32	2004 Improvements		2004	41,749						32
33	2005 Improvements		2005	46,688						33
34										34
35	Book Depreciation				218,045			218,045		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

Facility Name & ID Number The H J Vonderlieth Lvg Ctr

0019976

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	2006 Improvement	2006	\$ 64,093	\$		\$	\$	\$	37
38	2007 Improvement	2007	28,101						38
39	2008 Improvement	2008	25,035						39
40	2009 Improvement	2009	77,358						40
41	2010 Improvement	2010	31,481						41
42	2011 Improvement	2011	215,863						42
43	2012 Improvement	2012	63,565						43
44	2013 Improvement	2013	195,349						44
45	2014 Improvement	2014	84,511						45
46	2015 Improvement	2015	49,472						46
47	2016 Improvement	2016	411,479						47
48	2017 Improvement	2017	12,272						48
49	2018 Improvement	2018	75,527						49
50	2019 Improvement	2019	67,315						50
51									51
52	Install blinds - common area	2020	3,004						52
53	Replace Trane air handler	2020	3,126						53
54	Replace check valves - lift station	2020	2,957						54
55									55
56	Replace boiler and related piping	2021	592,388						56
57	Replace double doors	2021	8,283						57
58	Construct new cabinets and install new flooring for								58
59	nurses station	2021	3,285						59
60	Replace boiler room pump	2021	29,222						60
61	Replace windows throughout entire facility	2021	39,550						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,551,111	\$ 218,045		\$ 218,045	\$	\$	70

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

Facility Name & ID Number The H J Vonderlieth Lvg Ctr

0019976

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,551,111	\$ 218,045		\$ 218,045	\$	\$	1
2	PTAC replacement	2022	2,902						2
3	Installed (2) water heaters	2022	29,472						3
4	Installed (4) VFC vertical cabinet units	2022	6,507						4
5	Installed filter housing and piping - Boiler/HVAC systsem	2022	6,599						5
6	Flooring Project -	2022	169,114						6
7	Removed all previous layers of VCT vinyl flooring								7
8	and replaced with new luxury vinyl planks in								8
9	the following areas:								9
10	All hallway corridors								10
11	Activity & Therapy rooms								11
12	Men's & Women's bathrooms								12
13	Front entry and lobby								13
14	Costs included abatement of asbestos								14
15	in certain areas								15
16									16
17	Replace failed control board	2023	5,345						17
18	Upgrade dining room floor -	2023	14,329						18
19	Remove existing floor tile and mastic (abate asbestos)								19
20	Install new cove base vinyl floor tile								20
21	Replace resin - (2) water softeners	2023	3,200						21
22	Install (2) new vertical fan coil cabinets	2023	3,957						22
23	Replaced compressor in chiller	2023	43,473						23
24	Replace roof - south side of facility and porch	2023	29,656						24
25									25
26	Installed 2nd chiller and replaced electrical feeder	2024	179,048						26
27	conductors and circuit breakers on the existing chiller								27
28	Replaced damaged water line - kitchen	2024	3,454						28
29	Replaced countertops - North Nurse Station	2024	3,985						29
30	Excavated & disposed existing concrete and sod at	2024	60,458						30
31	various locations on facility property; formed and poured								31
32	new concrete at said locations								32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,112,610	\$ 218,045		\$ 218,045	\$	\$	34

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

Facility Name & ID Number The H J Vonderlieth Lvg Ctr

0019976

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,112,610	\$ 218,045		\$ 218,045	\$	\$	1
2	Purchased, installed and connected new generator	2025	62,745						2
3	Replaced heater unit - motor on old unit caught on fire	2025	3,843						3
4	and ruined								4
5	Removed existing landscape in front of the building, in								5
6	the courtyard and around the new generator - replaced								6
7	with mixture of decorative growl, shrubs and landscape								7
8	rocks; replaced lighting along driveway and courtyard	2025	38,679						8
9	Chiller (2) repairs - cleaned coils, replaced suction and	2025	14,458						9
10	discharge transducers								10
11	Removed existing surface on rear facility driveway and	2025	23,868						11
12	replaced with new base and top layer								12
13	Removed and replaced cabinetry, flooring and tub in	2025	28,160						13
14	resident room #200								14
15	Facility parking lot - installed 2" of state approved	2025	106,500						15
16	asphalt mix to the entire lot and restriped accordingly								16
17	Fire Sprinkler System - Replaced leaking 4" main pipe	2025	7,477						17
18	and replaced (5) dry pendent sprinkler heads								18
19	Installed new split heating/colling system in kitchen	2025	10,743						19
20	Fabricated and installed two sections of handrails	2025	4,850						20
21	Installed Wander Guard safety system throughout	2025	65,037						21
22	entire facility. System includes wearable tags and door monitors								22
23	Rebuilt 6" backflow device on relief valve	2025	8,388						23
24	Installed new video surveillance system	2025	26,287						24
25	Installed new power supply with battery backup	2025	2,853						25
26	for nurse call system								26
27	Roof - Replaced entire roof due to weather damage.	2025	496,301						27
28	Insurance adjustment is pending. Replacement included								28
29	new gutters and downspouts								29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,012,799	\$ 218,045		\$ 218,045	\$	\$	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	\$ 1,468,514	\$ 28,795	\$ 28,795	\$		\$	71
72	Current Year Purchases	80,421						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,548,935	\$ 28,795	\$ 28,795	\$		\$	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		2021 Chevy Equinox	2021	\$ 9,970	\$ 1,424	\$ 1,424	\$		\$	76
77		2020 Chrysler Voyager	2021	45,890	6,556	6,556				77
78										78
79										79
80	TOTALS			\$ 55,860	\$ 7,980	\$ 7,980	\$		\$	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)	\$ 8,617,594	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 254,820	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 254,820	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)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:None
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☒ XX NO Terms:

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

15. Is Movable equipment rental included in building rental?☐ YES☒ XX NO
16. Rental Amount for movable equipment: \$42,339 Description:Oxygen concentrators, copiers and printers
(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	None		\$	\$	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.

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)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 139,611	\$		\$ 139,611	1
2	Licensed Speech and Language Development Therapist		hrs			87,248			87,248	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			168,431	0		168,431	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				108,339		108,339	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,248			9,248	13
14	TOTAL			\$		\$ 404,538	\$ 108,339		\$ 512,877	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 319,277	\$	1
2	Cash-Patient Deposits	10,013		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	340,014		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	228,968		6
7	Other Prepaid Expenses	19,104		7
8	Accounts Receivable (owners or related parties)	1,663		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 919,039	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	321,268		13
14	Buildings, at Historical Cost	6,693,195		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,604,795		16
17	Accumulated Depreciation (book methods)	(5,976,084)		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)	\$ 2,643,174	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,562,213	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,351	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,013		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,654		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,346		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	29,491		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 417,855	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,669,270		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,669,270	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,087,125	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 475,088	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,562,213	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (328,492)	1
2	Restatements (describe):		2
3	Post closing adjustment - Payable to VLC Trust	(5,141)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (333,633)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	808,721	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)	\$ 808,721	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)	\$ 475,088	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The H J Vonderlieth Lvg Ctr

0019976

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,944,217	1
2	Discounts and Allowances for all Levels	(912,052)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,032,165	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	943,914	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 943,914	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	56,004	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	24,000	16
17	Sale of Drugs	199,151	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	114	19
20	Radiology and X-Ray		20
21	Other Medical Services	22,597	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 301,866	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,300	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,300	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Item - Receipt of Employee Retention	590,252	28
28a	Credit		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 590,252	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,889,497	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,194,896	31
32	Health Care	2,821,911	32
33	General Administration	2,371,520	33
	B. Capital Expense		
34	Ownership	297,159	34
	C. Ancillary Expense		
35	Special Cost Centers	395,290	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,080,776	40
41	Income before Income Taxes (line 30 minus line 40)**	808,721	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 808,721	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 291,615.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	736,610.37	45
46	MMAI-Medicaid is the Primary Payer	180,712.63	46
47	MMAI-Medicare is the Primary Payer	9,673.00	47
48	Private Pay	3,995,620.58	48
49	Medicare Part A	578,497.00	49
50	Other-(specify) Private Insurance	217,391.42	50
51	Other-(specify) Equipment Rental	24,769.00	51
52	Other-(specify) Medicare Cost Report Settlement	10,181.00	52
53	Other-(specify) Medicare Bad Debts	-12,905.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,032,165	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	1,965	2,068	\$ 102,805	\$ 49.71	1
2	Assistant Director of Nursing	2,196	2,312	89,260	38.61	2
3	Registered Nurses	9,824	10,341	457,381	44.23	3
4	Licensed Practical Nurses	6,945	7,311	266,886	36.50	4
5	CNAs & Orderlies	42,450	44,684	1,237,374	27.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,809	7,167	126,253	17.62	10
11	Social Service Workers	1,834	1,930	48,250	25.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,376	16,185	296,085	18.29	15
16	Dishwashers					16
17	Maintenance Workers	5,330	5,610	153,061	27.28	17
18	Housekeepers	7,747	8,155	143,209	17.56	18
19	Laundry	3,152	3,318	54,350	16.38	19
20	Administrator	1,976	2,080	144,584	69.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,366	13,017	340,988	26.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Employee Scholars	201	201	5,664	28.18	33
34	TOTAL (lines 1 - 33)	118,171	124,379	\$ 3,466,150 *	\$ 27.87	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		\$ 6,751	Ln 1 Col 3	35
36	Medical Director		24,000	Ln 9 Col 3	36
37	Medical Records Consultant		1,338	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,844	Ln 10a Col 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		3,525	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,458		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	727	\$ 49,022	Ln10 Col 3	50
51	Licensed Practical Nurses	1,100	60,003	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	3,099	98,065	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	4,926	\$ 207,090		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberThe H J Vonderlieth Lvg Ctr# 0019976Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Donna Kincade

Administrator

\$ 144,584

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

(List each licensed administrator separately.)

\$ 144,584

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

Heritage Operations Group

Management

\$ 362,033

David Fehrenbacher

Medicare consulting

1,000

David Underwood

Public Aid consulting

1,350

Striegel Knobloch & Co

Retirement plan admin

3,095

Legal adj to Zero

986

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

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

\$ 368,464

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 79,893

Unemployment Compensation Insurance

(2,660)

FICA Taxes

265,160

Employee Health Insurance

225,805

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits

65,452

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

\$ 633,650

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

18,187

Health Care Worker Background Check

(Indicate # of checks performed)

1,779

Patient Background Checks

Association Dues (total from pg 22, #4)

15,660

120

5,459

Less: Public Relations Expense

()

PAC and Lobbying payments

(7,830)

All non-allowable advertising

(266)

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

\$ 33,109

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

386

Seminar Expense

1,565

Entertainment Expense

()

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

TOTAL

\$ 1,951

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	7,830
	7,830 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)	7,830
	7,830 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	15,660
	15,660 Total
- (5)

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

\$ 5,000 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 346,964

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None Has any meal income been offset against related costs?

None Indicate the amount. \$ None
- (12)

Travel and Transportation

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

No If YES, attach a complete explanation.

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

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$

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

100%

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?

NA

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

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (13)

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

Firm Name: Eck, Schafer & Punke Yes
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details. None Claimed

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

[illegible]

Vonderlieth Living Center
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 108,339
Purchased Hospital Services	748
Purchased Laboratory Services	5,025
Purchased Radiology Services	3,475
Amount Reclassified to Line 39	\$ <u>117,587</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee	<u>346,964</u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>	
Pharmacy Consultant	\$ <u>4,844</u>

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>	
MDS Coordinators/Care Planners - Line 21, Col 1	\$ (140,710)
Medical Records Specialists - Line 21, Col 1	<u>(39,167)</u>
	<u>(179,877)</u>
Nursing & Medical Records Line 10	<u>179,877</u>