

		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: <u>0057448</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Hickory Vlg Nrsg Rhb</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> 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.	
Address: <u>9246 S Roberts Road</u> <u>Hickory Hills</u> <u>60457</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>708-598-4040</u> Fax # <u>708-598-3796</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>07/01/2022</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mendel S Schneider</u>			
Telephone Number: <u>847-933-1274</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) <u>See Accountant's Report Attached</u> (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u>	
		<u>4051 Old Orchard Rd Skokie Illinois 60076</u>	
		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	
		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 Hickory Vlg Nrsg Rhb # 0057448 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>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>40</u>	<u>14,600</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</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	4,361	15,043	2,231		616	1,472	59	23,782	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,361	15,043	2,231		616	1,472	59	23,782	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.05%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 07/01/22

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/22 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 34

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Hickory Vlg Nrsg Rhb # 0057448 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	320,199	17,105	6,811	344,115		344,115		344,115			1
2	Food Purchase		219,980		219,980		219,980	(444)	219,536			2
3	Housekeeping	203,350	27,408	28,874	259,632		259,632		259,632			3
4	Laundry	37,597	6,798		44,395		44,395		44,395			4
5	Heat and Other Utilities			56,114	56,114		56,114	1,692	57,806			5
6	Maintenance	99,281		41,594	140,875		140,875	2,883	143,758			6
7	Other (specify):*											7
8	TOTAL General Services	660,427	271,291	133,393	1,065,111		1,065,111	4,131	1,069,242			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	2,320,603	77,871	18,695	2,417,169		2,417,169		2,417,169			10
10a	Therapy											10a
11	Activities	152,164	6,338		158,502		158,502		158,502			11
12	Social Services	113,302	1,915		115,217		115,217		115,217			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,586,069	86,124	26,695	2,698,888		2,698,888		2,698,888			16
	C. General Administration											
17	Administrative	146,429		281,977	428,406		428,406	(281,977)	146,429			17
18	Directors Fees											18
19	Professional Services			128,692	128,692		128,692	60,164	188,856			19
20	Dues, Fees, Subscriptions & Promotions			76,320	76,320		76,320	(13,386)	62,934			20
21	Clerical & General Office Expenses	154,619	59,109	116,126	329,854		329,854	49,611	379,465			21
22	Employee Benefits & Payroll Taxes			508,355	508,355		508,355		508,355			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,578	2,578		2,578		2,578			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			244,508	244,508		244,508	485	244,993			26
27	Other (specify):* Allocated Benefits							12,982	12,982			27
28	TOTAL General Administration	301,048	59,109	1,358,556	1,718,713		1,718,713	(172,121)	1,546,592			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,547,544	416,524	1,518,644	5,482,712		5,482,712	(167,990)	5,314,722			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			35,985	35,985		35,985	154,824	190,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							341,551	341,551			32
33	Real Estate Taxes			258,724	258,724		258,724		258,724			33
34	Rent-Facility & Grounds			370,469	370,469		370,469	(368,707)	1,762			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			436,674	436,674		436,674	(436,674)				36
37	TOTAL Ownership			1,101,852	1,101,852		1,101,852	(309,006)	792,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,160	212,572	280,732		280,732		280,732			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			442,468	442,468		442,468		442,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		68,160	655,040	723,200		723,200		723,200			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,547,544	484,684	3,275,536	7,307,764		7,307,764	(476,996)	6,830,768			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,516	30		9
10	Interest and Other Investment Income	(36)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(444)	2		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	(8,997)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(436,674)	36		24
25	Fund Raising, Advertising and Promotional	(8,851)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (452,486)		\$	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)	(19,975)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,975)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (472,461)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (4,535)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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45				45
46				46
47				47
48				48
49	Total	(4,535)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[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

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	\$ 370,469	Hickory Village Property LLC		\$	(370,469)	1
2	V	30	Depreciation				152,308	152,308	2
3	V	32	Interest				341,587	341,587	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			\$ 370,469			\$ 493,895	\$ * 123,426	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 281,977	Jade Financial Services		\$	(281,977)	15
16	V	21	Office		Jade Financial Services		16,342	16,342	16
17	V	19	Professional Fees		Jade Financial Services		60,164	60,164	17
18	V	5	Utilities		Jade Financial Services		1,692	1,692	18
19	V	6	Repairs & Maintenance		Jade Financial Services		2,883	2,883	19
20	V	34	Rent		Jade Financial Services		1,762	1,762	20
21	V	21	Clerical Wages		Jade Financial Services		42,266	42,266	21
22	V	27	Allocated Benefits		Jade Financial Services		12,982	12,982	22
23	V	26	Insurance		Jade Financial Services		485	485	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			\$ 281,977			\$ 138,576	\$ * (143,401)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Hickory Vlg Nrsg Rhb								
ID#		0057448						
Report Period Beginning:		01/01/2025						
Ending:		12/31/2025						
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee	Building Co.	Management Co./Home Office	
-Owners of companies must be listed instead of company names.								
-Names of trust beneficiaries must be listed.								
First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage	
1	Jake	0	Mashiach	Chicago	IL	20.00000		1
2	Yechiel	0	Mashiach	Lincolnwood	IL	20.00000		2
3	Rhonda	0	Mashiach	Lincolnwood	IL	20.00000		3
4	Rita	0	Lipshitz	Skokie	IL	20.00000		4
5	Atied Associates, LLC	0	0	0	0	0.00000		5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000		6
7	Beneficiaries	0	0	0	0	0.00000		7
8	Rebecca	0	Rudolph	Evanston	IL	0.23077		8
9	Michael	0	Rudolph	Evanston	IL	0.23077		9
10	Zahava	0	Vales	Evanston	IL	0.23077		10
11	Raban	0	Vales	Evanston	IL	0.23077		11
12	Natan	0	Vales	Deerfield	IL	0.23077		12
13	Amidei	0	Vales	Deerfield	IL	0.23077		13
14	Cary	0	Silvers	Evanston	IL	0.23077		14
15	Jonathan	0	Silvers	Highland Park	IL	0.23077		15
16	Jacob	0	Silvers	Highland Park	IL	0.23077		16
17	Noam	0	Rothner	Teaneck	NJ	0.23077		17
18	Yonit	0	Rothner	Teaneck	NJ	0.23077		18
19	Hanna	0	Levine	Skokie	IL	0.23077		19
20	Nathan	0	Levine	Evanston	IL	0.23077		20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000		21
22	Beneficiaries	0	0	0	0	0.00000		22
23	Melisa	0	Rothner	Skokie	IL	0.75000		23
24	Daniel	0	Rothner	Teaneck	NJ	0.75000		24
25	William	0	Rothner	Skokie	IL	0.75000		25
26	Rachel	0	Rothner	Beachwood	OH	0.75000		26
27	0	0	0	0	0	0.00000		27
28	Daniel Rothner Accumu	0	0	0	0	0.00000		28
29	Beneficiaries	0	0	0	0	0.00000		29
30	Daniel	0	Rothner	Teaneck	NJ	1.00000		30
31	William Rothner Accumu	0	0	0	0	0.00000		31
32	Beneficiaries	0	0	0	0	0.00000		32
33	William	0	Rothner	Skokie	IL	1.00000		33
34	Melisa Rothner Accumu	0	0	0	0	0.00000		34
35	Beneficiaries	0	0	0	0	0.00000		35
36	Melisa	0	Rothner	Skokie	IL	1.00000		36
37	Rachel Rothner Accumu	0	0	0	0	0.00000		37
38	Rachel	0	Rothner	Beachwood	OH	1.00000		38
39	Adam Vales Accumulati	0	0	0	0	0.00000		39
40	Adam	0	Vales	Deerfield	IL	1.00000		40
41	Kathryn Vales Accumul	0	0	0	0	0.00000		41
42	kathryn	0	Vales	Highland park	IL	1.00000		42
43	Kimberly Vales Accumu	0	0	0	0	0.00000		43
44	Kimberly	0	Vales	Highland Park	IL	1.00000		44
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Facility Name & ID Number

Hickory Vlg Nrsg Rhb

0057448

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	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CEN	Joliet	Jade Financial Service	Skokie, IL	Mngmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis	Hickory Vil Prop	Skokie, IL	Bldg Rental	2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION C	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATIO	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION C	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITA	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER L	Tucson				8
9	ELMWOOD NURSING & REHABILITATION	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER I	Crestwood	DEVON GABLES REHABILITATION CENTE	Tucson				10
11	KENSINGTON NURSING AND REHABILITA	Chicago	ST. JAMES WELLNESS REHAB & VILLAS L	Crete				11
12	ABBINGTON VILLAGE NURSING AND REH	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILIT	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHAB	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	westwood Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION C	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION C	Rushville	RUSHVILLE NURSING REHABILITATION C	Rushville				20
21	NEIGHBORS REHABILITATION CENTER L	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER I	Champaign	PARK VILLA NURSING & REHABILITATIO	Palos Heights				22
23	Sheridan Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REH	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Wheaton Village & Nursing Center	Wheaton	UNIVERSITY REHABILITATION CENTER C	Urbana				25
26			PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27			BURBANK REHABILITATION CENTER LLC	Burbank				27
28			COUNTRYSIDE NURSING & REHABILITAT	Dolton				28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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 Hickory Vlg Nrsg Rhb # 0057448 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 Jade Financial Services LLC
Street Address 8707 Skokie Blvd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 213-1060
Fax Number ()

	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	21	Office	Number of Beds	1,231	10	\$ 271,852	\$	74	\$ 16,342	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		74	60,164	2
3	5	Utilities	Number of Beds	1,231	10	28,149		74	1,692	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		74	2,883	4
5	34	Rent	Number of Beds	1,231	10	29,319		74	1,762	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	74	42,266	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		74	12,982	7
8	26	Insurance	Number of Beds	1,231	10	8,068		74	485	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					\$ 2,305,240	\$ 703,094		\$ 138,576	25

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	Old National Bank		X	Mortgage			\$	3,820,454			\$	341,587	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	3,820,454			\$	341,587	9
	B. Non-Facility Related*												
10	Interest Income											(36)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(36)	14
15	TOTALS (line 9+line14)						\$	3,820,454			\$	341,551	15

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

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

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

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 Hickory Vlg Nrsg Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0057448

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 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. 23-01-302-021-0000	LTC Property	\$ 12,439.77	\$ 12,439.77
2. 23-02-420-007-0000	LTC Property	\$ 3,520.48	\$ 3,520.48
3. 23-02-420-008-0000	LTC Property	\$ 115,413.99	\$ 115,413.99
4. 23-02-420-015-0000	LTC Property	\$ 9,063.97	\$ 9,063.97
5. 23-02-420-016-0000	LTC Property	\$ 115,377.46	\$ 115,377.46
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 255,815.67	\$ 255,815.67

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,200 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2022	\$ 64,536	1
2					2
3	TOTALS			\$ 64,536	3

Facility Name & ID Number Hickory Vlg Nrsg Rhb

0057448

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	74		2022	1961	\$ 1,363,633	\$	10	\$ 136,363	\$ 136,363	\$ 477,271
5										
6										
7										
8										
	Improvement Type**									
9	Paint Wall Space/Door Frames on First Floor			2022	28,540		10	2,854	2,854	9,038
10	Electric Wiring-New Double Duplex Outlets-Rms 101-129			2022	29,970		10	2,997	2,997	9,990
11	Electric Wiring			2022	11,700		10	1,170	1,170	3,803
12	Floor Drains-Plumbing Work in 2 Shower Areas			2022	10,000		10	1,000	1,000	3,250
13	Replace Ejector Pump			2022	5,800		10	580	580	1,837
14	Boiler Repairs-Pilot Assembly & Burners			2022	4,991		10	499	499	1,580
15	Run Cable for Phone & Data in New Office & Maint Shop			2022	2,715		20	136	136	408
16	Landscaping_Patio Project			2023	80,796		10	8,080	8,080	20,324
17	New Hot Water Heater			2024	30,000		10	3,000	3,000	6,000
18	Generator Repair			2024	4,770		10	477	477	954
19	Fire Rated Door			2024	4,053		10	405	405	810
20	Landscaping Project			2024	32,870		10	3,287	3,287	6,574
21	Install Handrails,Bumper Guards in Corridors & Dining Rooms			2025	16,351		15	1,090	1,090	1,090
22	Rodding Underground Piping			2025	3,000		15	200	200	200
23	Repair Parking Lot			2025	5,870		15	391	391	391
24										
25										
26										
27										
28										
29										
30										
31										
32										
33	Financial Statement Depreciation					188,293			(188,293)	
34										
35										
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)		\$ 1,635,059	\$ 188,293		\$ 162,529	\$ (25,764)	\$ 543,520	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$197,960	\$	\$28,280	\$28,280	7	\$82,283	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$197,960	\$	\$28,280	\$28,280		\$82,283	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,897,555	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$188,293	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$190,809	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$625,803	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Jade				1,762			6
7	TOTAL				\$1,762			7

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

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

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
- Beginning
- Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 100,562	\$		\$ 100,562	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,832			15,832	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			96,178			96,178	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				18,562		18,562	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					49,598		49,598	12
13	Other (specify):									13
14	TOTAL			\$		\$ 212,572	\$ 68,160		\$ 280,732	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 35,110	\$ 35,110	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	955,033	955,033	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	529,754	529,754	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Other</u>	61,591	61,591	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,581,488	\$ 1,581,488	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		375,342	13
14	Buildings, at Historical Cost		1,363,633	14
15	Leasehold Improvements, at Historical Cost	268,711	268,711	15
16	Equipment, at Historical Cost	63,799	2,237,247	16
17	Accumulated Depreciation (book methods)	(89,300)	(622,378)	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)	\$ 243,210	\$ 3,622,555	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,824,698	\$ 5,204,043	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 843,389	\$ 843,389	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,863	212,863	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,403	7,403	31
32	Accrued Real Estate Taxes(Sch.IX-B)	268,607	268,607	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related</u>	1,455,897	1,455,897	36
37	<u>Due to Others</u>	163,711	163,711	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,951,870	\$ 2,951,870	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,820,454	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)	\$	\$ 3,820,454	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,951,870	\$ 6,772,324	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,127,172)	\$ (1,568,281)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,824,698	\$ 5,204,043	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,183,175)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,183,175)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	56,003	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)	\$ 56,003	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)	\$ (1,127,172)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hickory Vlg Nrsg Rhb

0057448

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	\$ 7,338,736	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,338,736	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	24,995	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,995	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,363,767	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,065,111	31
32	Health Care	2,698,888	32
33	General Administration	1,718,713	33
	B. Capital Expense		
34	Ownership	1,101,852	34
	C. Ancillary Expense		
35	Special Cost Centers	280,732	35
36	Provider Participation Fee	442,468	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,307,764	40
41	Income before Income Taxes (line 30 minus line 40)**	56,003	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 56,003	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,137,400.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,332,565.00	45
46	MMAI-Medicaid is the Primary Payer	480,502.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	134,268.00	48
49	Medicare Part A	1,117,115.00	49
50	Other-(specify) Medicare-B	102,005.00	50
51	Other-(specify) Insurance	34,881.00	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)	\$ 7,338,736	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	2,032	2,158	\$ 127,640	\$ 59.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,374	11,166	565,665	50.66	3
4	Licensed Practical Nurses	12,179	12,963	535,834	41.34	4
5	CNAs & Orderlies	34,096	37,533	948,011	25.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,866	2,082	52,600	25.26	9
10	Activity Assistants	4,766	5,271	99,564	18.89	10
11	Social Service Workers	4,161	4,593	113,302	24.67	11
12	Dietician					12
13	Food Service Supervisor	2,089	2,275	67,721	29.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,066	10,340	252,478	24.42	15
16	Dishwashers					16
17	Maintenance Workers	3,763	3,975	99,281	24.98	17
18	Housekeepers	9,501	10,498	203,350	19.37	18
19	Laundry	1,443	1,716	37,597	21.91	19
20	Administrator	1,952	2,080	146,429	70.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,853	4,165	154,619	37.12	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	1,779	1,964	52,642	26.80	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,987	2,120	90,811	42.84	33
34	TOTAL (lines 1 - 33)	104,907	114,899	\$ 3,547,544 *	\$ 30.88	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	\$ 6,811	1-3	35
36	Medical Director	Monthly	8,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,000	10-3	38
39	Pharmacist Consultant	Monthly	5,210	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,021		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	8	485	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 485		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Jennifer Kinnas	Administrator	0	\$ 146,429	Workers' Compensation Insurance		\$ 33,461	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		18,209	Advertising: Employee Recruitment	39,240	
				FICA Taxes		259,389	Health Care Worker Background Check	1,634	
				Employee Health Insurance		197,296	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	13,606	
							Netsmart	3,828	
							RADAR	2,136	
							Various	5,035	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 146,429				Less: Public Relations Expense	()	
B. Administrative - Other							PAC and Lobbying payments	(4,535)	
Description			Amount				All non-allowable advertising	()	
Jade Financial-Mgmt Fees			\$ 281,977				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 62,934		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 281,977	TOTAL (agree to Schedule V, line 22, col.8)			\$ 508,355		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Mendel Schneider CPA	Accounting		\$ 10,400				Out-of-State Travel	\$	
RothCo	Accounting		3,552						
Elizabeth Nash	Reimb Cons		28,800						
Guided Care	Case Mgmt		25,978				In-State Travel		
Neil Gerber Eisenberg	Legal		29,884						
Much Shelist	Legal		840						
Polsineli PC	Legal		8,330						
Sher LLP	Legal		10,984				Seminar Expense		
Stout	Appraisal		5,513				Various	2,578	
Goodnicki LLP	Legal		3,149						
Personnel Planners	UC Tax Cons		1,262						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense ()		
(For legal fee disclosure, see page 39 of instructions)			\$ 128,692				(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 2,578	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>9,071</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>9,071</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>4,535</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>4,535</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>13,606</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>13,606</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 11,605 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. \$ 442,468
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? 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? 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?
- d. Have vehicle usage logs been maintained?
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- g. Does the facility transport residents to and from day training? 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? No
Firm Name:
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.