

		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>0057968</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Ignite Medical Hanover Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</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>2000 West Lake St</u> <u>Hanover Park</u> <u>60133</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(630) 556-2000</u> Fax # <u>(630) 823-5454</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u></td></tr><tr><td>(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u>	(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u>	(Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</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																																				
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Date of Initial License for Current Owners: <u>06/01/2023</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____	
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In the event there are further questions about this report, please contact:																																																	
Name: <u>Andrew B. Cutler</u>		Telephone Number: <u>(847) 940-3269</u>																																															
Email Address: _____																																																	

Facility Name & ID Number Ignite Medical Hanover Park # 0057968 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</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>150</u>	TOTALS	<u>150</u>	<u>54,750</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	6,531	1,707	1,381	452	1,609	13,509	10,000	35,189	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,531	1,707	1,381	452	1,609	13,509	10,000	35,189	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 64.27%

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 06/01/2023

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/01/2023 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 150

Medicare Intermediary Wiaconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Ignite Medical Hanover Park # 0057968 Report Period Beginning: 1/1/2025 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	540,052	48,678	6,116	594,846		594,846		594,846			1
2	Food Purchase		257,184		257,184		257,184	(36,826)	220,358			2
3	Housekeeping	201,646	41,728		243,374		243,374	337	243,711			3
4	Laundry	35,350	23,433		58,783		58,783		58,783			4
5	Heat and Other Utilities			341,972	341,972		341,972	894	342,866			5
6	Maintenance	102,260	177	272,210	374,647		374,647	396	375,043			6
7	Other (specify):*											7
8	TOTAL General Services	879,308	371,200	620,298	1,870,806		1,870,806	(35,199)	1,835,607			8
	B. Health Care and Programs											
9	Medical Director			57,500	57,500		57,500		57,500			9
10	Nursing and Medical Records	4,344,470	616,170	57,224	5,017,864		5,017,864		5,017,864			10
10a	Therapy											10a
11	Activities	99,334		2,720	102,054		102,054		102,054			11
12	Social Services	421,746	4,188	2,317	428,251		428,251		428,251			12
13	CNA Training											13
14	Program Transportation			16,733	16,733		16,733		16,733			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,865,550	620,358	136,494	5,622,402		5,622,402		5,622,402			16
	C. General Administration											
17	Administrative	200,370		911,998	1,112,368		1,112,368	(889,813)	222,555			17
18	Directors Fees											18
19	Professional Services			347,350	347,350		347,350	(8,691)	338,659			19
20	Dues, Fees, Subscriptions & Promotions			81,553	81,553		81,553	(8,088)	73,465			20
21	Clerical & General Office Expenses	266,607	32,544	922,052	1,221,203		1,221,203	(463,495)	757,708			21
22	Employee Benefits & Payroll Taxes			959,837	959,837		959,837		959,837			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,591	3,591		3,591	3,454	7,045			24
25	Other Admin. Staff Transportation			22,389	22,389		22,389	1,640	24,029			25
26	Insurance-Prop.Liab.Malpractice			283,390	283,390		283,390	4,514	287,904			26
27	Other (specify):*							52,978	52,978			27
28	TOTAL General Administration	466,977	32,544	3,532,160	4,031,681		4,031,681	(1,307,501)	2,724,180			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,211,835	1,024,102	4,288,952	11,524,889		11,524,889	(1,342,700)	10,182,189			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			56,499	56,499		56,499	576,870	633,369			30
31	Amortization of Pre-Op. & Org.							15	15			31
32	Interest			5,525	5,525		5,525	1,513,517	1,519,042			32
33	Real Estate Taxes							823,169	823,169			33
34	Rent-Facility & Grounds			2,527,301	2,527,301		2,527,301	(2,518,006)	9,295			34
35	Rent-Equipment & Vehicles			20,041	20,041		20,041	41,821	61,862			35
36	Other (specify):*							127,978	127,978			36
37	TOTAL Ownership			2,609,366	2,609,366		2,609,366	565,364	3,174,730			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		625,612	1,616,114	2,241,726		2,241,726		2,241,726			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			72,406	72,406		72,406		72,406			41
42	Provider Participation Fee			384,997	384,997		384,997		384,997			42
43	Other (specify):* Marketing			65,293	65,293		65,293	(63,504)	1,789			43
44	TOTAL Special Cost Centers		625,612	2,138,810	2,764,422		2,764,422	(63,504)	2,700,918			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,211,835	1,649,714	9,037,128	16,898,677		16,898,677	(840,840)	16,057,837			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	(36,826)	02		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	(174,789)	30		9
10	Interest and Other Investment Income	(2,313)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	3,311	21		18
19	Entertainment	(480)	21		19
20	Contributions	(9,706)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(546,755)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(161,496)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(94,084)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,023,138)		\$	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)	182,298		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 182,298		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (840,840)		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	\$ (10,800)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Food-Hospitality	(56)	21	3
4	Marketing Expense	(63,504)	43	4
5	Internet Advertising	(60)	20	5
6	Non-Allowable Bank Fees and Late Charges	(19,664)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(94,084)		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
See Ownership Listing-1		See Page 6 - Supplemental		See Page 6 - Supplemental		

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

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 2,527,301	Ignite Hanover Park Property, LLC		\$	(2,527,301)	1
2	V	33	Real Estate Tax		Ignite Hanover Park Property, LLC		823,169	823,169	2
3	V	19	Professional Fees		Ignite Hanover Park Property, LLC		7,574	7,574	3
4	V	32	Interest Expense		Ignite Hanover Park Property, LLC		1,515,830	1,515,830	4
5	V	30	Depreciation		Ignite Hanover Park Property, LLC		741,605	741,605	5
6	V	36	Amortization		Ignite Hanover Park Property, LLC		127,978	127,978	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,527,301			\$ 3,216,156	\$ * 688,855	14

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

*** 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	39	Therapy	\$ 1,214,511	Spark Therapy		\$ 1,214,511	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,214,511			\$ 1,214,511	\$ *	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Ignite Medical Hanover Park								
ID#		0057968						
1/1/2025								
12/31/2025								
Report Period Beginning:					Ignite Team Partners, L			
Ending:					Ignite Hanover Park Property, LLC			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management			
-Owners of companies must be listed instead of company names.					Co./Home Office			
-Names of trust beneficiaries must be listed.					Ownership Percentage			
First Name		M.I.	Last Name	City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Ownership Percentage
1	Timothy		Fields	South Barrington	IL	20.56000	20.62500	50.00000
2	Barry		Carr	Lake Forest	IL	16.56000	16.62500	50.00000
3	James		White	Fort Myers	FL	1.11000	1.25000	
4	Matt		Thengil	Wheeling	IL	1.11000	1.25000	
5	Nicole		Jablonski	Johnsburg	IL	1.11000	1.25000	
6	Marc		Rose	West Chester	PA	1.11000	1.25000	
7	John		McFarlane	Parkville	MO	1.11000	1.25000	
8	Jared		Carr	Chicago	IL	3.11000	3.25000	
9	Ryan		Gobst	Chicago	IL	2.00000	2.00000	
10	Karen		Gillis	Batavia	IL	1.11000	1.25000	
11	Amy		Hammond	Mokena	IL	1.11000	0.00000	
12								
13	Ignite Villa Holdco LLC:							
14	Berger Family Trust							
15	Beneficiary:							
16	Aviva	N	Berger	Chicago	IL	16.67000	16.67000	
17	& all descendants of Menachem Berger except his son Moshe Berger							
18	Stern Family Trust							
19	Beneficiary:							
20	Todd	A	Stern	Skokie	IL	16.66500	16.66500	
21								
22	Israel Family Investment Trust							
23	Beneficiary:							
24	Benjamin	A	Israel	Lincolnwood	IL	8.33500	8.33500	
25	and the descendants of Yehudis Esther Israel							
26	Yehudis	E	Israel	Lincolnwood	IL	8.33000	8.33000	
27								
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64								
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67								
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69								
70								
71								
72								
73								
74								
75								

Facility Name & ID Number

Ignite Medical Hanover Park

0057968

Report Period Beginning:

1/1/2025

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	Ignite Medical Resort Adams Parc	Bartlesville, OK	Ignite Medical St. Peters	St. Peters, MO	Ignite Team Partners	Park Ridge, IL	Management Co.	1
2	Ignite Medical Resort Blue Springs	Blue Springs, MO	Ignite Medical Resort Edmond (2026)	Oklahoma City, OK	Spark Therapy	Park Ridge, IL	Therapy	2
3	Ignite Medical Resort Carondelet	Kansas City, MO	Ignite Medical Resort West Houston (2026)	Houston, TX	Kindle PIC	Park Ridge, IL	GL/PL, WC Ins.	3
4	Ignite Medical Resort KC Northland	Kansas City, MO			Ignite Hanover Park			4
5	Ignite Medical Resort Rainbow Blvd	Kansas City, MO			Property	Park Ridge, IL	Building Co.	5
6	Ignite Medical Resort McHenry	Hanover Park, IL						6
7	Ignite Medical Resort Norman	Norman, OK						7
8	Ignite Medical Resort Luxe Life Norman ALF	Norman, OK						8
9	Ignite Medical Resort Sugar Land	Sugar Land, TX						9
10	Ignite Medical Resort OKC	Oklahoma City, OK						10
11	Ignite Medical Resort St. Mary's	Blue Springs, MO						11
12	Ignite Medical Resort St. Mary's ALF	Blue Springs, MO						12
13	Ignite Medical Resort Fort Worth	Fort Worth, TX						13
14	Ignite Medical Resort Fort Worth ALF	Fort Worth, TX						14
15	Ignite Medical Resort Round Rock	Austin, TX						15
16	Ignite Medical Resort San Antonio	San Antonio, TX						16
17	Ignite Medical Resort Webster	Webster, TX						17
18	Ignite Medical Resort Crown Point	Crown Point, IN						18
19	Ignite Medical Resort Crown Point ALF	Crown Point, IN						19
20	Ignite Medical Resort Dyer	Dyer, IN						20
21	Ignite Medical Resort Dyer ALF	Dyer, IN						21
22	Ignite Medical Resort Katy	Katy, TX						22
23	Ignite Medical Resort Katy ALF	Katy, TX						23
24	Ignite Medical Resort Chesterton	Chesterton, IN						24
25	Ignite Medical Resort Chesterton ALF	Chesterton, IN						25
26	Ignite Medical Resort Overland Park	Overland Park, KS						26
27	Ignite Medical Resort El Paso	El Paso, TX						27
28	Ignite Medical Resort El Paso ALF	El Paso, TX						28
29	Ignite Medical Resort Tulsa	Tulsa, OK						29
30	Ignite Medical Batavia	Batavia, IL						30

VII. RELATED PARTIES (continued)

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

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

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

()

	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	3	Housekeeping	Patient Days	778,190	35	\$ 7,460	\$	35,189	\$ 337	1
2	5	Utilities	Patient Days	778,190	35	19,768		35,189	894	2
3	6	Maintenance	Patient Days	778,190	35	8,757		35,189	396	3
4	17	Administrative Salaries	Patient Days	778,190	35	2,237,158	2,237,158	35,189	101,162	4
5	19	Professional Fees	Patient Days	778,190	35	567,607		35,189	25,667	5
6	20	Dues, Fees, Subscriptions	Patient Days	778,190	35	275,945		35,189	12,478	6
7	21	Clerical & Office Salaries	Patient Days	778,190	35	5,039,037	5,039,037	35,189	227,860	7
8	21	Office Expense	Patient Days	778,190	35	885,756		35,189	40,053	8
9	24	Training & Education	Patient Days	778,190	35	76,378		35,189	3,454	9
10	25	Transportation	Patient Days	778,190	35	311,942		35,189	14,106	10
11	26	Insurance	Patient Days	778,190	35	99,815		35,189	4,514	11
12	27	Employee Benefits	Patient Days	778,190	35	1,171,595		35,189	52,978	12
13	30	Depreciation	Patient Days	778,190	35	222,335		35,189	10,054	13
14	31	Amortization	Patient Days	778,190	35	333		35,189	15	14
15	34	Rent	Patient Days	778,190	35	205,557		35,189	9,295	15
16	35	Auto Rental	Patient Days	778,190	35	136,724		35,189	6,183	16
17	35	Equipment Rental	Patient Days	778,190	35	788,114		35,189	35,638	17
18	17	Non-Allowable Compensation	Direct Allocation	(78,977)	6	(78,977)	(78,977)	(78,977)	(78,977)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 11,975,304	\$ 7,197,218		\$ 466,107	25

Facility Name & ID Number Ignite Medical Hanover Park # 0057968 Report Period Beginning: 1/1/2025 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 Spark Therapy
Street Address 1550 N. Northwest Highway, Suite 430
City / State / Zip Code Paerk Ridge, IL 60068
Phone Number (847)453-4000
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy				\$	\$		\$ 1,214,511	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					\$	\$		\$ 1,214,511	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	Mortgage		X	Mortgage			\$	19,763,850			\$	1,515,830	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Working Capital				600,000				4,140	6
7													7
8													8
9	TOTAL Facility Related						\$	20,363,850			\$	1,519,970	9
	B. Non-Facility Related*												
10	Interest Income		X									(2,313)	10
11	Medicare Interest		X									1,385	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(928)	14
15	TOTALS (line 9+line14)						\$	20,363,850			\$	1,519,042	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	806,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	802,569	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,431)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	826,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	823,169	7
Assessed Value from Real Estate Tax Bill:	2024	2,458,500	8		
Real Estate Tax Bill for Calendar Year:	2020	741,017	9		
	2021	651,854	10		
	2022	751,779	11		
	2023	779,599	12		
	2024	802,569	13		
R/E Tax Accrual = \$802,569*1.03 = \$826,600 (Rounded)			16	LESS REFUND FROM LINE 6	16
			17	AMOUNT TO USE FOR RATE CALCULATION \$	17

FOR BHF USE ONLY	
14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
15	PLUS APPEAL COST FROM LINE 5 \$ 15
16	LESS REFUND FROM LINE 6 \$ 16
17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ignite Medical Hanover Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0057968

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847)940-3269 FAX #: (847) 964-5469

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. 06-36-309-033-0000	Long-Term Care Property	\$ 7,823.98	\$ 7,823.98
2. 06-36-407-021-0000	Long-Term Care Property	\$ 794,744.57	\$ 794,744.57
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 802,568.55	\$ 802,568.55

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:74,800
- B. General Construction Type:ExteriorBrickFrameSteelNumber of Stories2
- 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

X(b) Rent equipment from a Related Organization.

X(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

N/A
- 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)?

YESNOX

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

N/A

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

YESXNO

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		2023	\$1,250,000	1
2					2
3	TOTALS			\$1,250,000	3

Facility Name & ID Number Ignite Medical Hanover Park

0057968

Report Period Beginning:

1/1/2025

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	150		2023	2011	\$ 11,704,371	\$	35	\$ 334,411	\$ 334,411	\$ 864,887	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PTAC A/C Units / Resistance Heat (4)			2023	2,787		10	279	279	837	9
10	Repair wall in PT Gym			2023	3,163		20	158	158	474	10
11	Repair Domestic Hot Water Pump & Chiller			2023	6,094		20	305	305	915	11
12	Butterfly Valve Leak Repair			2023	6,853		20	343	343	1,029	12
13	Repair Makeup Unit, Boiller, System Changeover			2023	6,124		20	306	306	918	13
14	Elevator Repairs			2023	2,997		20	150	150	450	14
15	PTAC A/C Units / Resistance Heat (2)			2023	1,459		20	73	73	219	15
16	Backflow Replacement			2024	6,347		20	317	317	634	16
17	Thermal Expansion Tank			2024	11,768		20	588	588	1,176	17
18	Data Room Mini Split			2024	19,302		20	965	965	1,930	18
19	Insulate Piping on Roof			2024	7,919		20	396	396	792	19
20	Piping for RTU			2024	11,567		20	578	578	1,156	20
21	RTU HW Coil Replacement			2024	33,886		20	1,694	1,694	3,388	21
22	Rework control wiring for RTU			2024	10,227		20	511	511	1,022	22
23	Controller system for HVAC			2024	21,247		20	1,062	1,062	2,124	23
24	New Backflows and Piping			2024	7,812		20	391	391	782	24
25	AHU 2, 3 and Boiler controller replacements			2024	7,757		20	388	388	776	25
26	Condensate Drain Roof			2024	2,275		20	114	114	228	26
27	Expansion Tank			2024	5,198		20	260	260	520	27
28	RTU CW Coil Replacement			2024	28,940		20	1,447	1,447	1,894	28
29	Sprinkler System			2024	21,780		20	1,089	1,089	2,178	29
30	Kitchen Exhaust			2024	11,919		20	596	596	1,192	30
31	Fire Sprinkler			2024	2,798		20	140	140	280	31
32											32
33											33
34											34
35											35
36	Current Book Depreciation					808,158					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	Related Party		\$	\$		\$	\$	\$	37
38									38
39	Leashold Improvements:								39
40	Allocated Ignite Team Partners	2020	4,128			206	206	1,136	40
41	Allocated Ignite Team Partners	2021	1,654			83	83	289	41
42	Allocated Ignite Team Partners	2023	6,144			307	307	614	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)		\$ 11,956,516	\$ 808,158		\$ 347,157	\$ 347,157	\$ 891,840	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	\$4,723,664	\$	\$284,124	\$284,124	10	\$845,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated ITP	17,670		2,088	2,088		8,277	74
75	TOTALS	\$4,741,334	\$	\$286,212	\$286,212		\$853,777	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)	\$17,947,850	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$808,158	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$633,369	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(174,789)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,745,617	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:

N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		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 ITP				9,295			6
7	TOTAL				\$9,295			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:

YESNO

 Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$55,679

Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated ITP		\$	\$6,183	17
18					18
19					19
20					20
21	TOTAL		\$	\$6,183	21

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

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

Ignite Medical Hanover Park
0057968
Page 14 Supplemental
1/1/2025-12/31/2025

Copier/ Printers	18,712
Postage Machine	1,329
Allocation from Ignite Team Partners, LLC	<u>35,638</u>
Total	<u>55,679</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ 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
		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	39-03	hrs	\$		\$ 458,437	\$		\$ 458,437	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			193,616			193,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			562,457			562,457	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				618,576		618,576	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-02					7,036		7,036	12
13	Other (specify): See Attached	39-03				401,604			401,604	13
14	TOTAL			\$		\$ 1,616,114	\$ 625,612		\$ 2,241,726	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.

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Line	Description	Amount
39-2	Therapy Supplies	4,532
39-2	Supplies- Medical. Lab X-Ray	<u>2,504</u>
	Total	<u>7,036</u>
39-3	Respiratory Therapy	78,589
39-3	Laboratory Expense	235,208
39-3	X-Ray	44,834
39-3	Oxygen	6,798
39-3	Oxygen Equipment Rental	10,775
39-3	ITP Functional Cost - Therapy	6,552
39-3	Dysphagia Therapy	<u>18,848</u>
	Total	<u>401,604</u>

Facility Name & ID Number	Ignite Medical Hanover Park
--------------------------------------	------------------------------------

0057968

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2025**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 513,769	\$ 1,113,391	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (193,586))	2,865,351	2,865,351	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,766	58,766	6
7	Other Prepaid Expenses	82,240	82,240	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	26,182	1,650,011	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,546,308	\$ 5,769,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		875,000	13
14	Buildings, at Historical Cost		15,805,000	14
15	Leasehold Improvements, at Historical Cost	239,431	814,849	15
16	Equipment, at Historical Cost	237,465	1,206,703	16
17	Accumulated Depreciation (book methods)	(103,932)	(1,968,973)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		286,689	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(63,709)	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)	\$ 372,964	\$ 16,955,559	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,919,272	\$ 22,725,318	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,461,829	\$ 1,461,829	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	341,759	341,759	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		826,600	32
33	Accrued Interest Payable	1,370	124,416	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,404,958	\$ 3,354,604	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,763,850	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	679,167	679,167	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 679,167	\$ 20,443,017	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,084,125	\$ 23,797,621	46
47	TOTAL EQUITY(page 18, line 24)	\$ 835,147	\$ (1,072,303)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,919,272	\$ 22,725,318	48

***(See instructions.)**

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A. Current Assets		Operating	After Consolidation
9	Vision/Benefits Clearing accounts	877	877
	Dental Clearing	616	616
	Due from Park Ridge Insurance Holding	24,606	24,606
	Withholding - HSA	83	83
	Other Accounts Receivable		270,000
	Rent Receivable		972,327
	Escrow		381,502
		<u>26,182</u>	<u>1,650,011</u>
B. Long-Term Assets		Amount	
23		-	-
		-	-
		-	-
		<u>-</u>	<u>-</u>
		<u>-</u>	<u>-</u>
Other Current Liabilities		Amount	
36			-
		<u>-</u>	<u>-</u>
		<u>-</u>	<u>-</u>
Other Long-Term Liabilities		Amount	
43	Due to/from Prior Owner	191,280.00	191,280
	Insurance Exchange	208,071.00	208,071
	Due to/from IM Hanover Park	9,816.00	9,816
	Due to/from Ignite Hanover Park Property	<u>270,000.00</u>	<u>270,000</u>
		<u>679,167.00</u>	<u>679,167</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 695,768	1
2	Restatements (describe):		2
3	PY Equity Adjutment	15,001	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 710,769	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,424,378	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	(1,300,000)	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)	\$ 124,378	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)	\$ 835,147	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ignite Medical Hanover Park

0057968

Report Period Beginning: 1/1/2025

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	\$ 18,052,548	1
2	Discounts and Allowances for all Levels	(7,111,832)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,940,716	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,247,913	6
7	Oxygen	70,737	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,318,650	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	36,826	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	632,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	221,849	19
20	Radiology and X-Ray	44,665	20
21	Other Medical Services	77,908	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,013,484	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,313	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,313	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ACO/Shared Savings Revenue	37,229	28
28a	Misc. Income	10,663	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 47,892	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,323,055	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,870,806	31
32	Health Care	5,622,402	32
33	General Administration	4,031,681	33
	B. Capital Expense		
34	Ownership	2,609,366	34
	C. Ancillary Expense		
35	Special Cost Centers	2,379,425	35
36	Provider Participation Fee	384,997	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,898,677	40
41	Income before Income Taxes (line 30 minus line 40)**	1,424,378	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,424,378	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,492,819.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	390,176.00	45
46	MMAI-Medicaid is the Primary Payer	315,661.00	46
47	MMAI-Medicare is the Primary Payer	103,316.00	47
48	Private Pay	691,887.00	48
49	Medicare Part A	6,173,933.00	49
50	Other-(specify) Insurance	1,772,924.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,940,716	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	2,016	2,080	\$ 186,067	\$ 89.46	1
2	Assistant Director of Nursing	3,720	4,240	224,273	52.89	2
3	Registered Nurses	34,250	36,405	1,603,283	44.04	3
4	Licensed Practical Nurses	21,639	23,436	940,046	40.11	4
5	CNAs & Orderlies	51,707	55,630	1,287,824	23.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,080	55,509	26.69	9
10	Activity Assistants	2,469	2,612	43,825	16.78	10
11	Social Service Workers	9,738	10,417	421,746	40.49	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	76,357	36.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,892	22,789	463,695	20.35	15
16	Dishwashers					16
17	Maintenance Workers	3,411	3,681	102,260	27.78	17
18	Housekeepers	11,564	12,395	201,646	16.27	18
19	Laundry	1,902	2,206	35,350	16.02	19
20	Administrator	2,032	2,082	200,370	96.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,283	8,642	266,607	30.85	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	3,763	4,155	102,977	24.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,170	194,930	\$ 6,211,835 *	\$ 31.87	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	24	\$ 1,464	1-3	35
36	Medical Director	Monthly	57,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	ITP Alloc.	37,341	10-3	38
39	Pharmacist Consultant	Monthly	19,883	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	ITP Alloc.	2,720	11-3	44
45	Social Service Consultant	ITP Alloc.	2,317	12-3	45
46	Other(specify) Dietary	ITP Alloc.	4,652	1-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	\$ 125,877		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Sarah Kurth	Administrator	0%	\$ 200,370
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 200,370
B. Administrative - Other			
Description			Amount
Ignite Team Partners			\$ 911,998
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 911,998
C. Professional Services			
Vendor/Payee	Type		Amount
Paylocity	Payroll		\$ 37,765
SaaS Fees	See Attached		178,859
Legal Fees	See Attached		14,672
Professional Fees	See Attached		63,040
Accounting Fees	Roth & Co.		53,014
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 347,350
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 53,010
Unemployment Compensation Insurance			28,968
FICA Taxes			448,151
Employee Health Insurance			328,051
Employee Meals			6,558
Illinois Municipal Retirement Fund (IMRF)*			
Life Insurance- Employer Coverage			1,159
401K Employer Contribution			23,495
Employee Retention			64,481
Other Employee Benefits			5,964
TOTAL (agree to Schedule V, line 22, col.8)			\$ 959,837
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			\$ 2,959
Advertising: Employee Recruitment			30,305
Health Care Worker Background Check (Indicate # of checks performed _____)			2,856
Patient Background Checks			10,614
Association Dues (total from pg 22, #4)			21,600
Dues and Subscriptions			24,749
Employee Licenses and Certifications			304
Less: Public Relations Expense		(	)
PAC and Lobbying payments			(10,800)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 82,587
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			3,591
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 3,591

*** Attach copy of IMRF notifications**

****See instructions.**

C. Professional Services

Vendor	Type	Amount	
Professional Fees			
Achieve Accreditation	Accreditation Services	2520	
Compliance Institute LLC dba Compliagent	Compliance Services	1009	
WEX Admin Fee	Administrative Services	21	
Onyx Procurement Solutions	Procurement Services	1450	
Zimmet Healthcare Services Group	Reimbursement Consulting	5400	
The Joint Commission	Credentialling	3660	
CHUG	Strategic Advisors	580	
Etyre		1393	
Husch Blackwell		480	
MNS		750	
Ryan, LLC		14396	
Self Ins		273	
FGMK, LLC		1923	
HSA Fee		93	
ITP Consulting		29092	
Total Professional Fees		63040	
SaaS			
Managed Care Group	Revenue Recovery Consulting	4000	
MindWire, Inc.	Workforce Analytics	343	
Net Health Systems	EHR Software	7793	
Netsmart technologies	PBJ Consulting	1224	
Neuromersice, Inc.	VR Therapy Software	3842	
PAX Holdco - RADAR APPS, LLC	Singal Processing Solutions	5988	
Kno2 LLC		5040	
PCC	Electronic Health Records	66778	
Predictive Index, LLC	Talent Optimization Software	1001	
Reside Admissions	Admission Software	4876	
Source Tech - Inventory Management	Inventory Management Software	600	
Strategic Healthcare Programs	Data Analytics	4740	
Striv Technologies, LLC	Family Engagement & Reputation	795	
Wound Solutions	Woundcare tech	686	
Washsense DBA Arsana Health	Facility Care Surveillance	2250	
Telemedicine Solutions, LLC	Telemedicine	3455	
Zunta		1990	
Easy Shifts.com, LLC	Staff Scheduling Software	3200	
Wellsky Corp, DBA Careport Health, LLC	Patient Care Coordination	14527	
Earthmed		1041	
Energage		720	
Square	Online payments	83	
Exacare AI	Claims Mgmt	1200	
Clearpol		8760.04	
Data Service Partners		8600.12	
Clasp Group		2538.79	
Brandconnex, LLC		1529	
Advanced Entry		1945	
Activity Connection		141.95	
Direct Supply		1706.64	
JAMF Software		1148.2	
Adobe		1104.36	
Zoho		163.42	
Gemini Analytics		2800	
Homecare Pulse		2110.31	
ITP		2164.72	
Inovalon		7632.73	
Juro Online		341.34	
Total SaaS		178858.6	
Legal			
Scott and Krause	Legal	6157	
Ashman & Stein	Legal	774	
Husch Blackwell	Legal	882	
ITP	Legal	88	
Polsinelli	Legal	4011	
Sher	Legal	2760	
Total Legal		14672	
Total		256570.6	

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Date	Description	Amount
2/15/2025	Bill - Divvy: Sarah Kurth Portillo's Hot Dogs Lunch for new employee orientation	98.00
3/4/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	166.66
5/7/2025	Bill - Learning Care Group Inc	288.46
5/15/2025	Bill - Divvy: Mathew Thengil The Wigwam NARA (national association of rehab agencies) conference room rental deposit	45.64
5/15/2025	Bill - Divvy: Sarah Kurth Illinois Nursing Home Adm Conference registration fee	230.00
7/1/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	166.66
7/10/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	100.00
7/15/2025	Bill - Divvy: Mathew Thengil The Wigwam NARA (national association of rehab agencies) conference room rental deposit	43.82
7/15/2025	Bill - Divvy: Sarah Kurth Nawco Wound care nurse educational classes	175.00
7/15/2025	Bill - Divvy: Sarah Kurth Anfp Mike Hernandez....CDM credentialing exam registration fee	425.00
8/15/2025	Bill - Divvy: Sarah Kurth ServSafe Registration fees for food handlers certification	135.00
8/15/2025	Bill - Divvy: Sarah Kurth Illinois Nursing Home Adm INHAA conference	280.00
9/15/2025	Bill - Divvy: Mathew Thengil Nara Rehab Registration for logan knox for NARA	71.14
9/15/2025	Bill - Divvy: Mathew Thengil The Wigwam Presentation at NARA. Room rental	40.57
10/15/2025	Bill - Divvy: Amy Hammond Illinois Nursing Home Adm Continuing education	81.25
10/15/2025	Bill - Divvy: Sarah Kurth Pita Pit Accountability inservice team luncheon	322.25
11/15/2025	Bill - Divvy: Sarah Kurth Hobby Lobby Poster boards for skills fair	20.36
11/15/2025	Bill - Divvy: Marie Rosete Amazon Think Pink Shirts for wound prevention day!	214.94
11/15/2025	Bill - Divvy: Sarah Kurth Amazon Wound care tshirts for staff education	214.94
11/15/2025	Bill - Divvy: Sarah Kurth Healthcarec AHCA bronze quality award training	149.00
11/15/2025	Bill - Divvy: Sarah Kurth Panda Express Lunch for wound care training/education	172.48
11/15/2025	Bill - Divvy: Sarah Kurth Target Andago training and competition for highest usage	100.00
11/15/2025	Bill - Divvy: Sarah Kurth Target Gift cards for wound care training and celebration	50.00
		3,591.17

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
HEALTH CARE COUNCIL OF IL (HCCI)	10,800
	10,800 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	10,800
	10,800 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	21,600
	21,600 Total
- (5)

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

\$ 53,839 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.

\$ 384,997

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.

\$ 6,558 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 36,826
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

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

LN 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

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

N/A

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

No

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

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

Firm Name: N/A
- (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.