

		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>0056689</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Ignite Medical McHenry</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>550 Ridgeview Drive</u> <u>McHenry</u> <u>60050</u>			
Number City Zip Code			
County: <u>McHenry</u>			
Telephone Number: <u>(815) 900-2500</u> Fax # <u>(847) 813-5729</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/17/2020</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>Andrew B.. Cutler</u>		Telephone Number: <u>(847) 940-3269</u>	
		Email Address: _____	
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		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 Banockburn, 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	

Facility Name & ID Number Ignite Medical McHenry # 0056689 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	84	Skilled (SNF)	84	30,660	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	84	TOTALS	84	30,660	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	3,575	3,569	665	239	2,874	10,865	7,089	28,876	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,575	3,569	665	239	2,874	10,865	7,089	28,876	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.18%

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 12/23/2020

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/25/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 84

Medicare Intermediary National Government 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 McHenry # 0056689 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	503,402	30,430	1,357	535,189		535,189		535,189			1
2	Food Purchase		239,204		239,204		239,204	(42,937)	196,267			2
3	Housekeeping	170,364	29,690		200,054		200,054	277	200,331			3
4	Laundry		7,171	9,265	16,436		16,436		16,436			4
5	Heat and Other Utilities			156,425	156,425		156,425	734	157,159			5
6	Maintenance	74,330	190,927		265,257		265,257	325	265,582			6
7	Other (specify):*											7
8	TOTAL General Services	748,096	497,422	167,047	1,412,565		1,412,565	(41,601)	1,370,964			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	3,876,444	167,826	45,366	4,089,636		4,089,636		4,089,636			10
10a	Therapy											10a
11	Activities	62,627	27,408		90,035		90,035		90,035			11
12	Social Services	430,165	4,837		435,002		435,002		435,002			12
13	CNA Training											13
14	Program Transportation	35,677		65,581	101,258		101,258		101,258			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,404,913	200,071	140,947	4,745,931		4,745,931		4,745,931			16
	C. General Administration											
17	Administrative	132,856		776,426	909,282		909,282	(758,221)	151,061			17
18	Directors Fees											18
19	Professional Services			296,243	296,243		296,243	8,720	304,963			19
20	Dues, Fees, Subscriptions & Promotions			67,884	67,884		67,884	6,451	74,335			20
21	Clerical & General Office Expenses	284,441	32,868	433,379	750,688		750,688	(79,166)	671,522			21
22	Employee Benefits & Payroll Taxes			994,735	994,735		994,735		994,735			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,547	2,547		2,547	2,834	5,381			24
25	Other Admin. Staff Transportation			9,755	9,755		9,755	1,345	11,100			25
26	Insurance-Prop.Liab.Malpractice			20,988	20,988		20,988	496,344	517,332			26
27	Other (specify):*							43,474	43,474			27
28	TOTAL General Administration	417,297	32,868	2,601,957	3,052,122		3,052,122	(278,219)	2,773,903			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,570,306	730,361	2,909,951	9,210,618		9,210,618	(319,820)	8,890,798			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			63,323	63,323		63,323	832,392	895,715			30
31	Amortization of Pre-Op. & Org.							12,504	12,504			31
32	Interest			654	654		654	1,249,778	1,250,432			32
33	Real Estate Taxes							345,600	345,600			33
34	Rent-Facility & Grounds			2,460,925	2,460,925		2,460,925	(2,453,297)	7,628			34
35	Rent-Equipment & Vehicles			17,961	17,961		17,961	34,317	52,278			35
36	Other (specify):*											36
37	TOTAL Ownership			2,542,863	2,542,863		2,542,863	21,294	2,564,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		546,395	1,501,837	2,048,232		2,048,232		2,048,232			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			57,617	57,617		57,617		57,617			41
42	Provider Participation Fee			175,895	175,895		175,895		175,895			42
43	Other (specify):*			96,432	96,432		96,432	(96,432)				43
44	TOTAL Special Cost Centers		546,395	1,831,781	2,378,176		2,378,176	(96,432)	2,281,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,570,306	1,276,756	7,284,595	14,131,657		14,131,657	(394,958)	13,736,699			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	(42,759)	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	(248,208)	30		9
10	Interest and Other Investment Income	(342)	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	(16,245)	21		18
19	Entertainment	(7,394)	21		19
20	Contributions	(9,006)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(233,885)	21		24
25	Fund Raising, Advertising and Promotional	(3,239)	21		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	(124,500)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (685,578)		\$	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)	290,620		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 290,620		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (394,958)		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	\$ (3,528)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Sales Tax	(69)	02	3
4	Food Hospitality	(109)	02	4
5	Marketing Expense	(96,432)	43	5
6	McHenry Chamber of Commerce	(260)	20	6
7	Non-Allowable Bank and Late Fees	(24,102)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(124,500)		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

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	\$ 2,523,457	McHenry Senior Partners, LLC		\$	(2,523,457)	1
2	V	32	Interest		McHenry Senior Partners, LLC		1,250,120	1,250,120	2
3	V	30	Depreciation		McHenry Senior Partners, LLC		1,072,350	1,072,350	3
4	V	31	Amortization		McHenry Senior Partners, LLC		12,492	12,492	4
5	V	26	Insurance		McHenry Senior Partners, LLC		492,640	492,640	5
6	V	19	Professional Fees		McHenry Senior Partners, LLC		33,235	33,235	6
7	V	34	Rent	(62,532)	McHenry Senior Partners, LLC			62,532	7
8	V	33	Real Estate Tax Expense		McHenry Senior Partners, LLC		345,600	345,600	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,460,925			\$ 3,206,437	\$ * 745,512	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	3	Housekeeping	\$	Ignite Team Partners, LLC		\$ 277	\$ 277	15
16	V	5	Utilities		Ignite Team Partners, LLC		734	734	16
17	V	6	Maintenance		Ignite Team Partners, LLC		325	325	17
18	V	12	Social Service Salaries		Ignite Team Partners, LLC				18
19	V	15	Health Care Employee Benefits		Ignite Team Partners, LLC				19
20	V	17	Administrative Salaries		Ignite Team Partners, LLC		83,013	83,013	20
21	V	19	Professional Fees	45,572	Ignite Team Partners, LLC		21,057	(24,515)	21
22	V	20	Dues, Fees, Subscriptions		Ignite Team Partners, LLC		10,239	10,239	22
23	V	21	Clerical & Office Salaries		Ignite Team Partners, LLC		186,982	186,982	23
24	V	21	Office Expense		Ignite Team Partners, LLC		27,723	27,723	24
25	V	24	Training & Education		Ignite Team Partners, LLC		2,834	2,834	25
26	V	25	Transportation		Ignite Team Partners, LLC		1,345	1,345	26
27	V	26	Insurance		Ignite Team Partners, LLC		3,704	3,704	27
28	V	27	Employee Benefits		Ignite Team Partners, LLC		43,474	43,474	28
29	V	30	Depreciation		Ignite Team Partners, LLC		8,250	8,250	29
30	V	34	Rent		Ignite Team Partners, LLC		7,628	7,628	30
31	V	35	Auto Rental		Ignite Team Partners, LLC		5,073	5,073	31
32	V	35	Equipment Rental		Ignite Team Partners, LLC		29,244	29,244	32
33	V	31	Amotization		Ignite Team Partners, LLC		12	12	33
34	V	17	Asset Management	77,642	Ignite Team Partners, LLC			(77,642)	34
35	V	17	Management Fee	698,784	Ignite Team Partners, LLC			(698,784)	35
36	V	17	Non-Allowable Compensation		Ignite Team Partners, LLC		(64,808)	(64,808)	36
37	V								37
38	V								38
39	Total			\$ 821,998			\$ 367,106	\$ * (454,892)	39

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

STATE OF ILLINOIS					Ownership Listing-1				
Ignite Medical McHenry									
ID#		0056689							
Report Period Beginning:		1/1/2025							
Ending:		12/31/2025			Ignite Team Partners, McHenry Senior Partners, 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				
Place of Residence					Building Co. Ownership Percentage				
First Name M.I. Last Name City State					Ownership Percentage				
1	William	F	Morton	Carmel	IN	1.65750	1.65750	0.00000	1
2	Christopher	J	King	Carmel	IN	1.65750	1.65750	0.00000	2
3	Thomas	C	Smith	Carmel	IN	4.42060	4.42000	0.00000	3
4	Leo	J	Brown	Carmel	IN	4.42060	4.42000	0.00000	4
5	Michael	R	Wagner	Indianapolis	IN	4.41890	4.42000	0.00000	5
6	Timothy		Fields	South Barrington	IL	6.56910	6.59750	50.00000	6
7	Barry		Carr	Lake Forest	IL	5.29510	5.32350	50.00000	7
8	James		White	Fort Myers	FL	0.39810	0.45500	0.00000	8
9	Mat		Thengil	Wheeling	IL	0.39810	0.45500	0.00000	9
10	Nicole		Jablonski	Johnsburg	IL	0.39810	0.45500	0.00000	10
11	Marc		Rose	West Chester	PA	0.39810	0.45500	0.00000	11
12	John		McFarlane	Parkville	MO	0.39810	0.45500	0.00000	12
13	Jared		Carr	Chicago	IL	1.03510	1.09200	0.00000	13
14	Ryan		Gobst	Chicago	IL	0.63700	0.63700	0.00000	14
15	Harvey		Knell	Pasadena	CA	67.50000	67.50000	0.00000	15
16	Amy		Hammond	Mokena	IL	0.39810	0.00000	0.00000	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									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									70
71									71
72									72
73									73
74									74
75									75

Facility Name & ID Number

Ignite Medical McHenry

0056689

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

Facility Name & ID Number Ignite Medical McHenry # 0056689 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 Ignite Team Partners, LLC
Street Address 1550 N. Northwest Highway, Suite 430
City / State / Zip Code Park Ridge, IL 60068
Phone Number (847) 453-4000
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	3	Housekeeping	Patient Days	778,190	37	\$ 7,460	\$	28,876	\$ 277	1
2	5	Utilities	Patient Days	778,190	37	19,768		28,876	734	2
3	6	Maintenance	Patient Days	778,190	37	8,757		28,876	325	3
4	12	Social Service Salalries	Patient Days	778,190	37			28,876	0	4
5	15	Health Care Employee Benefits	Patient Days	778,190	37			28,876	0	5
6	17	Administrative Salaries	Patient Days	778,190	37	2,237,158	2,237,158	28,876	83,013	6
7	19	Professional Fees	Patient Days	778,190	37	567,607		28,876	21,062	7
8	20	Dues, Fees, Subscriptions	Patient Days	778,190	37	275,945		28,876	10,239	8
9	21	Clerical & Office Salaries	Patient Days	778,190	37	5,039,037	5,039,037	28,876	186,982	9
10	21	Office Expense	Patient Days	778,190	37	885,756		28,876	32,867	10
11	24	Training & Education	Patient Days	778,190	37	76,378		28,876	2,834	11
12	25	Transportation	Patient Days	778,190	37	311,942		28,876	11,575	12
13	26	Insurance	Patient Days	778,190	37	99,815		28,876	3,704	13
14	27	Employee Benefits	Patient Days	778,190	37	1,171,595		28,876	43,474	14
15	30	Depreciation	Patient Days	778,190	37	222,335		28,876	8,250	15
16	34	Rent	Patient Days	778,190	37	205,557		28,876	7,628	16
17	35	Auto Rental	Patient Days	778,190	37	136,724		28,876	5,073	17
18	35	Equipment Rental	Patient Days	778,190	37	788,114		28,876	29,244	18
19	31	Amortization	Patient Days	778,190	37	333		28,876	12	19
20	17	Non-Allowablw Compensation	Direct Allocation	28,876	2	(64,808)	(64,808)	28,876	(64,808)	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 11,989,473	\$ 7,211,387		\$ 382,485	25

Facility Name & ID Number Ignite Medical McHenry # 0056689 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

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

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	HUD		X	Mortgage			\$	21,423,980			\$	1,260,808	1
2	TCF Bank		X	Van Loan				5,786				654	2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	21,429,766			\$	1,261,462	9
	B. Non-Facility Related*												
10	Interest Income		X									(342)	10
11	Interest Income		X									(10,688)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(11,030)	14
15	TOTALS (line 9+line14)						\$	21,429,766			\$	1,250,432	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 190,198 Line # 26

* 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.			\$	348,480	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.)			\$	327,871	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(20,609)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	366,209	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.			\$	345,600	7
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020	30,363	9		
	2021	189,715	10		
	2022	237,518	11		
	2023	307,020	12		
	2024	327,871	13		
R/E Tax Accrual - 327871 *1.117=\$366,209 - R/E tax are escrowed with Mortgage		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.

FACILITY NAME Ignite Medical McHenry COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0056689

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

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.

B. Real Estate Tax Cost Allocations

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.)

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

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:55,000B. General Construction Type:ExteriorCement/MasonryFrameWoodNumber of Stories1
- 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. (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. N/A
- G. Have you properly capitalized all major repairs and equipment purchases? Yes
- H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

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

1. Total Amount Incurred:437,2292. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:12,4924. 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	55,000	2020	\$1,103,269	1
2					2
3	TOTALS	55,000		\$1,103,269	3

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	84		2020	2020	\$ 11,791,913	\$	40	\$ 294,798	\$ 294,798	\$ 1,473,990
5										
6										
7										
8										
	Improvement Type**									
9	Signs		2020		6,324		10	632	632	3,160
10	Grab Bars		2020		6,255		20	313	313	1,565
11	Nexus-Phone System		2020		26,791		20	1,340	1,340	6,700
12	Nexus Cameras		2021		2,775		20	139	139	695
13	Installation of Nexus Resident Phones Port & Extension		2021		3,180		20	159	159	795
14	Installation of Door Push		2021		4,953		20	248	248	1,240
15	Water Conditioner		2021		9,495		20	475	475	2,375
16	Storage Shed Tmg Industrial		2021		3,788		20	189	189	945
17	930 Cable Replacement for all Console Proper Operation		2022		4,250		20	213	213	692
18	Dialysis Room Construction Plumbing and Electric		2022		20,000		20	1,000	1,000	3,750
19	Reception Area Starbucks Costruction - Plumbing and Electric		2022		14,486		20	724	724	2,595
20	Pipe Fire Protection Dry System		2024		15,888		20	794	794	1,588
21	Sprinkler System		2025		3,472		20	116	116	116
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36	Book Depreciation					1,143,923				

*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	2021	36,747			1,837	1,837		39
40	2021	139,949			6,997	6,997		40
41								41
42								42
43								43
44								44
45	2020	3,387		20	169	169	932	45
46	2021	1,357		20	68	68	237	46
47	2023	5,042		20	252	252	504	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		\$ 12,100,052	\$ 1,143,923		\$ 310,463	\$ 310,463	\$ 1,501,879	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	\$4,259,449	\$	\$568,281	\$568,281		\$2,977,653	71
72	Current Year Purchases	48,844		3,871	3,871	3-5	3,871	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$4,308,293	\$	\$572,152	\$572,152		\$2,981,524	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		Van	2020	\$38,495	\$	\$6,003	\$6,003	5	\$38,495	76
77		Auto	2020	6,184		1,030	1,030	5	6,184	77
78		Auto	2020	2,210		405	405	5	2,210	78
79		SUV	2024	28,311		5,662	5,662	5	6,134	79
80	TOTALS			\$75,200	\$	\$13,100	\$13,100		\$53,023	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)	\$17,586,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,143,923	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$895,715	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(248,208)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,536,426	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.

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		Allocation ITP						6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

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: \$16,533Description: 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	Allocation ITP		\$	\$	17
18	Facility Patient Transpor	2021 Caddilac XT5	499.53	1,428	18
19					19
20					20
21	TOTAL		\$499.53	\$1,428	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 McHenry
0056689
Equipment Rental
12/31/2025

Copier	16,379
Postage Machine/Office Lease	<u>154</u>
Total	<u><u>16,533</u></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	39-3	hrs	\$		\$ 400,000	\$		\$ 400,000	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			144,129			144,129	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			600,000			600,000	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				503,116		503,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					43,279		43,279	12
13	Other (specify): See Attached	39-3				357,708			357,708	13
14	TOTAL			\$		\$ 1,501,837	\$ 546,395		\$ 2,048,232	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.

Line	Description	Amount
39-2	Therapy Supplies	2,002
39-2	IV Insertion and PICC Line	<u>41,227</u>
	Total	<u>43,229</u>
39-3	Wound Care	12,746
39-3	Consolidated Billing	2,780
39-3	Respiratory Therapy	71,234
39-3	Laboratory Expense	160,663
39-3	X-Ray	19,521
39-3	Oxygen	6,651
39-3	Oxygen Equipment Rental	5,629
39-3	Dysphagia Therapy	4,376
39-3	Durable Medical Equipment	11,153
39-3	Medical Equipment Rental	50,658
39-3	Therapy Equipment Rental	<u>12,297</u>
	Total	<u>357,708</u>

A. Current Assets		Operating	After Consolidation
9	Due to/from ITP	16,188	16,188
	Due to/from Leo Brown Group	(6,846)	(6,846)
	Due to/from Park Ridge Ins Holding	24,606	24,606
	Lease Receivable		191,939
	Due to/from IMR McHenry	(5,889)	(5,889)
	Escrow Deposits		214,240
	Other Reserve		82,671
		28,059	516,909
B. Long-Term Assets		Amount	
23	Right of Use Asset*	8,456,316.00	8,456,316
	ROU Asset Offset*	8,456,316	8,456,316
Other Current Liabilities		Amount	
36	Accrued Management Fee	65,402	65,402
	Accrued Bed Tax/QOC	14,778	14,778
	Accrued Expenses	45,682	45,682
	Garnsihements Clearing Account	996	996
	Unclaimed Property	54	54
	Withholding HSA	188	188
		127,100	127,100
Other Long-Term Liabilities		Amount	
43	Lease Liability LT*	9,076,365.00	9,076,365
	Lease Liability Offset*	-	
		9,076,365.00	9,076,365

* After Consolidation nets to \$0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 963,130	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 963,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,404,201	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	(1,270,000)	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)	\$ 134,201	17
	B. Transfers (Itemize):		
18			18
19	Rounding	(2)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,097,329	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ignite Medical McHenry

0056689

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	\$ 15,334,091	1
2	Discounts and Allowances for all Levels	(5,917,453)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,416,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,223,349	6
7	Oxygen	53,881	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,277,230	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	42,759	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	524,588	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	133,634	19
20	Radiology and X-Ray	19,165	20
21	Other Medical Services	115,342	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 835,488	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	342	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 342	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ACO Shared Savings/QIP/PFP	6,025	28
28a	Misc. Income	135	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,160	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,535,858	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,412,565	31
32	Health Care	4,745,931	32
33	General Administration	3,052,122	33
	B. Capital Expense		
34	Ownership	2,542,863	34
	C. Ancillary Expense		
35	Special Cost Centers	2,202,281	35
36	Provider Participation Fee	175,895	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,131,657	40
41	Income before Income Taxes (line 30 minus line 40)**	1,404,201	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,404,201	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 587,206.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	586,221.00	45
46	MMAI-Medicaid is the Primary Payer	109,229.00	46
47	MMAI-Medicare is the Primary Payer	39,257.00	47
48	Private Pay	1,281,666.00	48
49	Medicare Part A	5,080,956.00	49
50	Other-(specify)	1,732,103.00	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)	\$ 9,416,638	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	2,080	\$ 159,563	\$ 76.71	1
2	Assistant Director of Nursing	3,667	3,984	212,920	53.44	2
3	Registered Nurses	27,748	29,346	1,395,983	47.57	3
4	Licensed Practical Nurses	17,840	18,582	786,964	42.35	4
5	CNAs & Orderlies	50,077	52,445	1,267,512	24.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,963	2,052	61,306	29.88	9
10	Activity Assistants	68	73	1,321	18.10	10
11	Social Service Workers	9,962	10,530	430,166	40.85	11
12	Dietician	23	28	753	26.89	12
13	Food Service Supervisor					13
14	Head Cook	1,412	1,487	64,945	43.68	14
15	Cook Helpers/Assistants	18,001	18,742	386,302	20.61	15
16	Dishwashers	1,903	1,999	51,402	25.71	16
17	Maintenance Workers	1,748	1,894	74,330	39.24	17
18	Housekeepers	8,178	8,664	170,364	19.66	18
19	Laundry					19
20	Administrator	2,032	2,080	132,856	63.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,633	9,136	284,440	31.13	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	1,892	2,050	53,502	26.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Driver</u>	1,681	1,792	35,677	19.91	33
34	TOTAL (lines 1 - 33)	158,860	166,964	\$ 5,570,306 *	\$ 33.36	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	23	\$ 1,357	1-3	35
36	Medical Director	346	30,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	203	16,498	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)	572	\$ 47,855		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.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number Ignite Medical McHenry # 0056689 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
<u>Matthew Bauchle</u>	<u>Administrator</u>	<u>0</u>	<u>132,856</u>
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			<u>\$ 132,856</u>

B. Administrative - Other

Description	Amount
<u>Asset Management Fee - Leo Brown Group</u>	<u>\$ 77,642</u>
<u>Management Fee - ITP</u>	<u>698,784</u>
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	<u>\$ 776,426</u>

C. Professional Services

Vendor/Payee	Type	Amount
<u>Paylocity</u>	<u>Payroll</u>	<u>\$ 33,455</u>
<u>Inovalon</u>	<u>Revenue Cycle Management</u>	<u>8,060</u>
<u>Efax</u>	<u>Cloud Fax</u>	<u>2,723</u>
<u>Adobe</u>	<u>Software</u>	<u>1,104</u>
<u>Advanced Entry</u>	<u>Software and Kiosk</u>	<u>1,745</u>
<u>Clasp Group</u>	<u>Recruitment</u>	<u>2,539</u>
<u>Clearpol</u>	<u>AI Healthcare Compliance</u>	<u>760</u>
<u>Data Service Partners</u>	<u>Cloud Reporting Systems</u>	<u>8,600</u>
<u>Direct Supply</u>	<u>Technology Solutions</u>	<u>3,964</u>
<u>Easy Shifts</u>	<u>Intel Pro Subscription</u>	<u>3,200</u>
<u>Energage</u>	<u>Talent Acquisition Software</u>	<u>720</u>
<u>See Attached</u>	<u>Various</u>	<u>229,373</u>
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		<u>\$ 296,243</u>

D. Employee Benefits and Payroll Taxes

Description	Amount
<u>Workers' Compensation Insurance</u>	<u>\$ 152,965</u>
<u>Unemployment Compensation Insurance</u>	<u>25,138</u>
<u>FICA Taxes</u>	<u>386,601</u>
<u>Employee Health Insurance</u>	<u>311,034</u>
<u>Employee Meals</u>	<u>13,066</u>
<u>Illinois Municipal Retirement Fund (IMRF)*</u>	
<u>Uniforms</u>	<u>11,243</u>
<u>Other Employee Benefits</u>	<u>9,846</u>
<u>Employee Retention</u>	<u>81,232</u>
<u>Life Insurance</u>	<u>948</u>
<u>401K</u>	<u>2,662</u>
TOTAL (agree to Schedule V, line 22, col.8)	<u>\$ 994,735</u>

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

Description	Line #	Amount
		<u>\$</u>
TOTAL		<u>\$</u>

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
<u>IDPH License Fee</u>	<u>\$ 2,035</u>
<u>Advertising: Employee Recruitment</u>	<u>37,050</u>
<u>Health Care Worker Background Check</u> (Indicate # of checks performed _____)	<u>3,030</u>
<u>Patient Background Checks</u>	<u>8,493</u>
<u>Association Dues (total from pg 22, #4)</u>	<u>7,056</u>
<u>Dues and Subscriptions</u>	<u>7,945</u>
<u>Licenses and Certificates</u>	<u>838</u>
<u>Licenses and Permits</u>	<u>8,233</u>
<u>Alloc. ITP</u>	<u>10,239</u>
<u>Less: Public Relations Expense</u>	<u>(</u>
<u>PAC and Lobbying payments</u>	<u>(3,528)</u>
<u>All non-allowable advertising</u>	<u>(</u>
TOTAL (agree to Sch. V, line 20, col. 8)	<u>\$ 81,391</u>

G. Schedule of Travel and Seminar**

Description	Amount
<u>Out-of-State Travel</u>	<u>\$</u>
<u>In-State Travel</u>	
<u>Seminar Expense</u>	<u>5,381</u>
<u>Entertainment Expense</u>	<u>(</u>
TOTAL (agree to Sch. V, line 24, col. 8)	<u>\$ 5,381</u>

* Attach copy of IMRF notifications

**See instructions.

Professional Services

Vendor/Payee	Type	Amount
Activity Connection	Entertainment Activity Software	\$ 142.00
Ethermed	AI solutions/prior authorization	\$ 1,042.00
Exacare	AI solutions	\$ 1,200.00
Gemini Analytics	Data Analytics	\$ 2,800.00
Heartlegacy Salesmail	Salesmail app	\$ 1,164.00
Homecare Pulse LLC dba Activated Insights	Healthcare technology	\$ 2,100.00
LICA-MedMan	Medication guide	\$ 35.00
Clasp group	Recruiting	\$ 393.00
Exclaimer Limited	Email signature mgmt solution	\$ 95.00
Kaseya	IT documentation portal	\$ 1,641.00
JAMF SOFTWARE, LLC	Ipad Software management	\$ 1,148.00
Juro Online Limited	AI contract solutions	\$ 341.00
Kami Vision	AI technology and security solutions	\$ 10,500.00
Managed Care Group LLC	Revenue Recovery Consulting	\$ 4,800.00
MindWire Inc	Workforce analytics	\$ 343.00
Net Health Systems Inc	EHR software	\$ 7,793.00
Netsmart Technologies Inc	PBJ consulting	\$ 1,937.00
Neuromersice Inc: VR Therapy software	Therapy system	\$ 3,842.00
PAX Holdco Inc dba RADAR APPS LLC	Revenue cycle management solution	\$ 5,988.00
PointClickCare Technologies INC	Electronic health records	\$ 37,275.00
Predictive Index LLC	Talent Optimization software	\$ 1,001.00
Reside Admissions LLC	Admissions software	\$ 6,721.00
SNFCB	Consolidated billing	\$ 475.00
Source Tech (Integrated Inventory Technology Inc)	Inventory management software	\$ 600.00
Square	POS	\$ 86.00
Strategic Healthcare Programs LLC formerly Team T	Data Analytics	\$ 4,740.00
Striv Technologies LCC. DBA Striv360	Family engagement & reputation kios	\$ 795.00
Synapse Health LLC	DME ordering	\$ 420.00
Telemedicine	Telemedicine	\$ 3,455.00
The Perk Daily	Activity communication tool	\$ 8.00
Third Eye Health Inc	Telemedicine	\$ 6,180.00
WashSense dba Arsana Health	Facility care surveillance subscription	\$ 1,800.00
Wellsky Corporation dba Careport Health LLC	Referral management	\$ 7,254.00
Wound Solutions	AI healthcare solutions	\$ 686.00
Yelp	Business review	\$ 625.00
Zoho	Cloud software	\$ 163.00
Zunta	Automated billing	\$ 2,064.00
Achieve Compliance Group LLC	Compliance service	\$ 7,034.00
Collaborative Healthcare Urgency Group (CHUG)	CHUG membership	\$ 579.00
Compliance Institute	Compliance service	\$ 1,009.00
Deborah Connery Consulting LLC	Activities consulting	\$ 1,050.00
Entyre Solutions	Consulting services	\$ 1,393.00
HSA Fees	HSA	\$ 57.00
Scott & Kraus	Legal Fees - master line	\$ 659.00
Olio health	longitudinal care coordination	\$ 1,125.00
4mybenefits	HR services	\$ 3,022.00
Luminate HCC	Payroll-Based Journal and Post-Acute	\$ 380.00
Ben Lazare	Government affairs	\$ 800.00
Creative planning	Employee retirement plan admin	\$ 1,255.00
Direct supply	Admin Services	\$ 278.00
COSEY SPEAKS	Healthcare Leader Consulting	\$ 2,994.00
ITP Consulting Fee	Consulting	\$ 14,308.00
Kerri Rudy	Care planning	\$ 330.00
Onyx Procurement Solutions LLC	Business management consultant	\$ 1,450.00
PCORI Fee	Self Insured health plans	\$ 304.00
Stephanie Kitzewow	Registration for dietitian	\$ 80.00
Stephen Smith	Early Lease Termination	\$ 5,325.00
The Joint Commission: H000655984	Accreditation services	\$ 3,230.00
Zimmet Healthcare Services Group, LLC	Reimburesment Consulting	\$ 5,400.00
WEX HEALTH INC	Employee benefits	\$ 30.00
FGMK	Tango lease software	\$ 1,923.00
National Datacare Corporation	Trust fund services	\$ (156.00)
Roth & Company	Accounting services	\$ 18,000.00
Blue & Co	Accounting services	\$ 8,050.00
FGMK	Accounting services	\$ 13,451.00
CBIZ Inc	Accounting services	\$ 1,092.00
Cassel plan audit	Accounting services	\$ 734.00
Sher, LLP	Legal	\$ 2,841.00
Scott & Kraus	Legal	\$ 1,892.00
Polsinelli	Legal	\$ 1,001.00
Amundsen Davis	Legal	\$ 5,598.00
Husch Blackwell, LLP	Legal	\$ 882.00
Foulston Seifkin	Legal	\$ 182.00
ITP Legal	Legal	\$ 139.00

Ignite Medical McHenry
0056689
Page 21 Supplemental
1/1/2025-12/31/2025

Legal

Date	Detail	Amount
1/31/2025	Bill - Sher, LLP	1,675.00
2/27/2025	SCOTT & KRAUS LLC INV #81305	1,891.90
3/1/2025	Bill - Polsinelli PC	273.00
3/27/2025	Bill - Sher, LLP	382.50
5/5/2025	Bill - Sher, LLP	758.75
5/16/2025	Bill - Foulston Siefkin LLP: March services	182.25
6/11/2025	Bill - Polsinelli PC	728.00
6/23/2025	Bill - Ignite Team Partners, LLC	139.05
8/19/2025	Bill - Amundsen Davis	4,342.50
8/27/2025	Bill - Sher, LLP	25.00
8/28/2025	Bill - Amundsen Davis	1,255.00
9/1/2025	Bill - Husch Blackwell LLP	882.00
Total		<u>12,534.95</u>

Ignite Medical McHenry
0056689
Page 21 Supplemental
1/1/2025-12/31/2025

Seminar

Date	Description	Amount
3/15/2025	Bill - Divvy: Marie Rosete Amazon Mc Henry Skills Fair ordered poster board, paper and supplies	161.92
3/15/2025	Bill - Divvy: Marie Rosete Office Max Skills Fair	33.00
3/15/2025	Bill - Divvy: Tiffany Yohn DoorDash Tiffany kendzior and tiffany yohn. Lunch and training.	18.99
3/27/2025	Bill - Russell Hammer dba Hammerdown CPR	510.00
4/15/2025	Bill - Divvy: Tiffany Yohn DoorDash Tiffany kednzior. Tiffany matras. Lunch and training team collaboration and planning	53.93
4/15/2025	Bill - Divvy: Tiffany Yohn DoorDash Tiffany kednzior. Tiffany matras. Lunch and training team collaboration and planning. Chiplote forgot some food.	16.71
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
6/15/2025	Bill - Divvy: Stephen Smith Premier Food Safety Food safety cert for new dofi	7.95
7/10/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	100.00
7/15/2025	Bill - Divvy: Marie Rosete Office Max Education and orientation	40.33
7/15/2025	Bill - Divvy: Mathew Thengil The Wigwam NARA (national association of rehab agencies) conference room rental deposit	43.82
7/26/2025	Bill - Randy Alarcon	337.00
8/15/2025	Bill - Divvy: Erica Dewan Dementia CE for licensure - Traversing Dementia Care in the Western Suburbs: A Conference for Caregivers and Professionals	27.16
8/27/2025	Bill - Cayla Simmons	195.00
9/15/2025	Bill - Divvy: Mathew Thengil Nara Rehab Registration for logan knox for NARA	35.57
9/15/2025	Bill - Divvy: Sondra Mixdorf Dollar General Supplies for skills fair on Fall management at facility	38.07
9/15/2025	Bill - Divvy: Sondra Mixdorf Dollar Tree Supplies for skills fair on Fall management at facility	30.92
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: Tiffany Yohn DoorDash Marie adkins cm. Justin meara and tiffany yohn. Lunch and learn training	33.34
11/15/2025	Bill - Divvy: Marie Rosete Stephaniesw Think Pink t shirts for clinical team for skin prevention week	247.00
11/15/2025	Bill - Divvy: Marie Rosete Walgreens Staff appreciation after survey	59.90
12/15/2025	Bill - Divvy: Marie Rosete Eb Infection Preventi Infection control training Mc Henry Acno/IP	100.00
	Allocated ITP	2,834.00
	Total	5,380.53

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)

3,528

3,528 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)

3,528

3,528 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

7,056

7,056 Total
- (5)

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

\$

53,489

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.

\$

175,895

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.

\$

13,066

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

42,759
- (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

No
- (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.