

		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: 0058503

Facility Name: Inverness Rehab

Address: 1800 Colonial Parkwy Inverness 60067

NumberCityZip Code

County: Cook

Telephone Number: 847-776-4700 Fax # 847-991-4104

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2023

Type of Ownership:

☐

VOLUNTARY, NON-PROFIT

☐

Charitable Corp.

☐

Trust

IRS Exemption Code

☒

PROPRIETARY

☐

Individual

☐

Partnership

☐

Corporation

☐

"Sub-S" Corp.

☒

Limited Liability Co.

☐

Trust

☐

Other

☐

GOVERNMENTAL

☐

State

☐

County

☐

Other

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

Name: David ShamsiTelephone Number: 847-983-4860

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Aaron Topper

(Title) President

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number Inverness Rehab # 0058503 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 _____					
	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>142</u>	Skilled (SNF)	<u>142</u>	<u>51,830</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>142</u>	TOTALS	<u>142</u>	<u>51,830</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	7,703	19,635	4,365	47	5,716	3,343	446	41,255	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,703	19,635	4,365	47	5,716	3,343	446	41,255	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 79.60%

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

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

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 12/1/2023

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/2023 NO ☐

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

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Inverness Rehab # 0058503 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	507,591	27,638	57,219	592,448		592,448		592,448			1
2	Food Purchase		343,196		343,196		343,196		343,196			2
3	Housekeeping	292,425	48,318		340,743		340,743		340,743			3
4	Laundry	106,617	47,792		154,409		154,409		154,409			4
5	Heat and Other Utilities			281,380	281,380		281,380		281,380			5
6	Maintenance	168,961	30,452	222,496	421,909		421,909		421,909			6
7	Other (specify):*											7
8	TOTAL General Services	1,075,594	497,396	561,095	2,134,085		2,134,085		2,134,085			8
	B. Health Care and Programs											
9	Medical Director			18,774	18,774		18,774		18,774			9
10	Nursing and Medical Records	3,517,799	205,641	1,053,371	4,776,811		4,776,811		4,776,811			10
10a	Therapy			742,191	742,191		742,191		742,191			10a
11	Activities	91,110	5,868	6,888	103,866		103,866		103,866			11
12	Social Services	92,317			92,317		92,317		92,317			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,701,226	211,509	1,821,224	5,733,959		5,733,959		5,733,959			16
	C. General Administration											
17	Administrative	140,940		677,329	818,269		818,269		818,269			17
18	Directors Fees											18
19	Professional Services			46,424	46,424		46,424		46,424			19
20	Dues, Fees, Subscriptions & Promotions			19,634	19,634		19,634	(8,507)	11,127			20
21	Clerical & General Office Expenses	556,740		1,522,887	2,079,627		2,079,627	(246,094)	1,833,533			21
22	Employee Benefits & Payroll Taxes			853,219	853,219		853,219		853,219			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			258,122	258,122		258,122		258,122			26
27	Other (specify):*											27
28	TOTAL General Administration	697,680		3,377,616	4,075,296		4,075,296	(254,601)	3,820,695			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,474,499	708,905	5,759,935	11,943,340		11,943,340	(254,601)	11,688,739			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			36,290	36,290		36,290		36,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,228	19,228		19,228		19,228			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			835,417	835,417		835,417		835,417			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			890,935	890,935		890,935		890,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			38,769	38,769		38,769		38,769			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			750,400	750,400		750,400		750,400			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			789,169	789,169		789,169		789,169			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,474,499	708,905	7,440,039	13,623,444		13,623,444	(254,601)	13,368,843			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30,495)	21		18
19	Entertainment				19
20	Contributions	(2,400)	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	(203,199)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (246,094)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (246,094)		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	\$ (8,507)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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	(8,507)		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
		Pavilion of Waukegan	Waukegan	Pavilion of Waukegan	Waukegan	Realty
		Park Place of Belvidere	Belvidere	Belvidere Care Center	Belvidere	Realty
		Northbrook Health and Rehab	Northbrook			

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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			\$			\$	\$	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			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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
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16								16
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19								19
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Topper	Owner	Mgmt	16.00	1,067,552			Mgmt fees	\$ 390,613	17-3	1
2	Sora Esther Cohen	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	2
3	Avraham Topper	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	3
4	Batsheva Jenah	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	4
5	Elisha Topper	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	5
6	Shalva Topper	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	6
7	Zelda Topper	Owner	Mgmt	4.00	12,173			Mgmt fees	13,653	17-3	7
8	Igor Rebel	Owner	Mgmt	20.00	60,866			Mgmt fees	68,266	17-3	8
9	Akiva Brandman	Owner	Mgmt	3.64	11,066			Mgmt fees	12,412	17-3	9
10	Yaakov Brandman	Owner	Mgmt	3.64	11,066			Mgmt fees	12,412	17-3	10
11	Netanel Brandman	Owner	Mgmt	3.64	11,066			Mgmt fees	12,412	17-3	11
12	Chaviva Brandman	Owner	Mgmt	3.64	11,066			Mgmt fees	12,412	17-3	12
13								TOTAL	\$ 590,445		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 Inverness Rehab # 0058503 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

Facility Name & ID Number Inverness Rehab # 0058503 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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Lake Forest		x			3/15/25		466,100	3/1526	7.0000	19,228		6
7													7
8													8
9	TOTAL Facility Related						\$	466,100			\$ 19,228		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	466,100			\$ 19,228		15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	792,144	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.)				\$	792,144	2
3. Under or (over) accrual (line 2 minus line 1).				\$		3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	822,598	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.				\$		6
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.				\$	822,598	7
Assessed Value from Real Estate Tax Bill:	2024	2,480,001	8			
Real Estate Tax Bill for Calendar Year:	2020	591,365	9			
	2021	630,938	10			
	2022	616,608	11			
	2023	792,144	12			
	2024	822,598	13			
				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	Inverness Rehab	COUNTY	Cook
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CONTACT PERSON REGARDING THIS REPORT David Shamsi

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,690B. General Construction Type: Exterior Brick VeneerFrame WoodNumber of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

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

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

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

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

XI. OWNERSHIP COSTS:

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

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Piping replacement throughout the facility			2024	5,270	211	25	211		352
10	Renovations:			2024	167,068	11,138	15	11,138		15,091
11	a)Therapy room: flooring, millwork, painting of walls									
12	b)South Wing: fire place, TV wall, flooring, painting, design, stone, electric									
13										
14	Repairs to water pump in central mezzanine			2024	3,666	367	10	367		581
15	Outdoor sign			2024	4,542	454	10	454		530
16	3 hot water pumps			2024	6,835	684	10	684		741
17	Valve replacement at mechanical room/patient dividing wal			2024	5,195	346	15	346		404
18	Vinyl flooring, patient room			2025	2,582	258	10	258		258
19	Leaking valves relplacement above nurses station			2025	3,131	209	10	209		209
20	Outdoor sign			2025	3,075	282	10	282		282
21	Exit alarm			2025	5,502	504	10	504		504
22	Carpet flooring, dining area			2025	12,500	2,083	5	2,083		2,083
23	Ceramic flooring, dining area			2025	3,605	150	20	150		150
24	Compressor for fire systtem			2025	5,450	242	15	242		242
25	Washer and dryer			2025	3,600	120	10	120		120
26	Over repair			2025	2,511	63	10	63		63
27	Water pump replacement			2025	7,204	60	10	60		60
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$241,736	\$17,172		\$17,172	\$	\$21,671	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	\$71,247	\$19,469	\$19,469	\$		\$40,088	71
72	Current Year Purchases	3,981	341	341		various	341	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$75,228	\$19,810	\$19,810	\$		\$40,429	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)	\$316,964	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$36,982	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$36,982	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$62,100	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	2000	142	12/1/2023	\$ 697,125	1		3
4	Additions							4
5								5
6								6
7	TOTAL		142		\$ 697,125			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

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

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 34,883	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 339,709)	1,104,010		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,788		6
7	Other Prepaid Expenses	16,953		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security deposit	60,935		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,300,569	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	220,459		15
16	Equipment, at Historical Cost	75,228		16
17	Accumulated Depreciation (book methods)	(61,101)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 234,586	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,535,155	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 799,641	\$	26
27	Officer's Accounts Payable	(525,300)		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	466,100		29
30	Accrued Salaries Payable	264,084		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,913		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	other accrued expense	13,279		36
37	other liabilities	150,632		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,170,349	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,170,349	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 364,806	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,535,155	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 353,936	1
2	Restatements (describe):		2
3	Balance sheet rec	3,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 356,936	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,870	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 7,870	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)	\$ 364,806	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Inverness Rehab

0058503

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	\$ 12,918,567	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,918,567	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	552,166	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 552,166	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	132,291	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 132,291	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	28,290	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,290	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,631,314	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,134,085	31
32	Health Care	5,733,959	32
33	General Administration	4,075,296	33
	B. Capital Expense		
34	Ownership	890,935	34
	C. Ancillary Expense		
35	Special Cost Centers	38,769	35
36	Provider Participation Fee	750,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,623,444	40
41	Income before Income Taxes (line 30 minus line 40)**	7,870	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,870	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,100,333.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,084,264.00	45
46	MMAI-Medicaid is the Primary Payer	1,130,268.00	46
47	MMAI-Medicare is the Primary Payer	12,170.00	47
48	Private Pay	1,884,320.00	48
49	Medicare Part A	2,417,292.00	49
50	Other-(specify) Managed Care - Medicare	289,920.00	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)	\$ 12,918,567	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,926	1,926	\$ 133,249	\$ 69.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,116	13,116	599,540	45.71	3
4	Licensed Practical Nurses	24,884	24,884	990,182	39.79	4
5	CNAs & Orderlies	75,274	75,274	1,741,738	23.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,115	2,115	50,646	23.95	9
10	Activity Assistants	2,428	2,428	40,464	16.67	10
11	Social Service Workers	3,314	3,314	92,317	27.86	11
12	Dietician	19,212	19,212	379,262	19.74	12
13	Food Service Supervisor					13
14	Head Cook	5,631	5,631	127,924	22.72	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,003	4,003	116,992	29.23	17
18	Housekeepers	16,917	16,917	292,425	17.29	18
19	Laundry	5,916	5,916	106,617	18.02	19
20	Administrator	2,126	2,126	140,940	66.29	20
21	Assistant Administrator					21
22	Other Administrative	19,073	19,073	534,280	28.01	22
23	Office Manager	2,086	2,086	74,160	35.55	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	2,090	2,090	53,763	25.72	27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,111	200,111	\$ 5,474,499 *	\$ 27.36	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		\$ 57,219		35
36	Medical Director		18,774		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,444		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		6,888		44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 92,325		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 304,010		50
51	Licensed Practical Nurses		256,361		51
52	Certified Nurse Assistants/Aides		119,445		52
53	TOTAL (lines 50 - 52)		\$ 679,816		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberInverness Rehab

0058503

Report Period Beginning:1/1/2025

Page 21

Ending:12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Benjamin Ornelas

Administrator

0

\$ 62,660

Adam Aranov

Administrator

0

52,352

Reynaldo Querubin

Administrator

0

25,928

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

(List each licensed administrator separately.)

\$ 140,940

B. Administrative - Other

Description

Amount

Management

\$ 677,329

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 677,329

C. Professional Services

Vendor/Payee

Type

Amount

RothCo

Accounting

\$ 6,999

Scott Krause

Legal fees

4,826

Skidelsky & Associates

Legal fees

20,400

Stone Pogrund & Korey

Legal fees

831

Guided Care

Reimbursement

1,000

Prospect Resources

Utilities

1,200

Stout Risus Ross, Inc

Accounting

6,043

Old National

Field Exam

5,125

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

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

\$ 46,424

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 70,469

Unemployment Compensation Insurance

45,456

FICA Taxes

407,034

Employee Health Insurance

290,602

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401 k

20,341

Other employee benefits

19,317

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

\$ 853,219

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

9,169

Health Care Worker Background Check

1,700

(Indicate # of checks performed 155)

Patient Background Checks

Association Dues (total from pg 22, #4)

8,507

Activity Connection

258

Less: Public Relations Expense

()

PAC and Lobbying payments

(8,507)

All non-allowable advertising

()

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

\$ 11,127

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Entertainment Expense

()

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

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name	Amount
	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.

Williamsburg Village Owners Association	7,476
Other, please specify Collaborative Healthcare Urgency Group	1,031
	8,507 Total
- (4)

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

Williamsburg Village Owners Association	7,476
Other, please specify Collaborative Healthcare Urgency Group	1,031
	8,507 Total
- (5)

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

\$

Line
- (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.

\$

750,400

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

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

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

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

\$

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (12)

Travel and Transportation

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

If YES, attach a complete explanation.

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

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

\$

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

d. Have vehicle usage logs been maintained?

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

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

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

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

\$
- (13)

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

No

Firm Name:
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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