

		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>0052712</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Kensington Place Nrsg Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>3405 S Michigan Ave</u> <u>Chicago</u> <u>60616</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>708-598-4040</u> Fax # <u>312-791-0626</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>02/01/2014</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mendel S Schneider</u>			
Telephone Number: <u>847-933-1274</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) <u>See Accountant's Report Attached</u> (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u>	
		<u>4051 Old Orchard Rd Skokie Illinois 60076</u>	
		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	

Facility Name & ID Number Kensington Place Nrsng Rehab # 0052712 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	6,711	28,906	7,279		382	4,626	456	48,360	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,711	28,906	7,279		382	4,626	456	48,360	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 85.48%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 02/01/14

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 02/01/14 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 155

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ 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 **Kensington Place Nrsg Rehab** # **0052712** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	439,223	38,298	11,657	489,178		489,178		489,178			1
2	Food Purchase		392,187		392,187		392,187	(1,000)	391,187			2
3	Housekeeping	294,939	39,778	86,492	421,209		421,209		421,209			3
4	Laundry	128,186	19,399		147,585		147,585		147,585			4
5	Heat and Other Utilities			192,018	192,018		192,018	3,544	195,562			5
6	Maintenance	179,685		106,504	286,189		286,189	6,040	292,229			6
7	Other (specify):*											7
8	TOTAL General Services	1,042,033	489,662	396,671	1,928,366		1,928,366	8,584	1,936,950			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,223,840	165,588	126,325	4,515,753		4,515,753		4,515,753			10
10a	Therapy											10a
11	Activities	156,214	1,491		157,705		157,705		157,705			11
12	Social Services	300,567	1,656		302,223		302,223		302,223			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,680,621	168,735	138,325	4,987,681		4,987,681		4,987,681			16
	C. General Administration											
17	Administrative	198,272		708,470	906,742		906,742	(708,470)	198,272			17
18	Directors Fees											18
19	Professional Services			122,081	122,081		122,081	126,018	248,099			19
20	Dues, Fees, Subscriptions & Promotions			105,013	105,013		105,013	(30,090)	74,923			20
21	Clerical & General Office Expenses	481,910	96,773	218,779	797,462		797,462	109,214	906,676			21
22	Employee Benefits & Payroll Taxes			889,714	889,714		889,714		889,714			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,474	4,474		4,474		4,474			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			412,657	412,657		412,657	42,457	455,114			26
27	Other (specify):* Allocated Benefits							27,192	27,192			27
28	TOTAL General Administration	680,182	96,773	2,461,188	3,238,143		3,238,143	(433,679)	2,804,464			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,402,836	755,170	2,996,184	10,154,190		10,154,190	(425,095)	9,729,095			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							278,635	278,635			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			81,485	81,485		81,485	1,467,319	1,548,804			32
33	Real Estate Taxes			669,588	669,588		669,588		669,588			33
34	Rent-Facility & Grounds			1,463,569	1,463,569		1,463,569	(1,459,877)	3,692			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			225,560	225,560		225,560	(225,560)				36
37	TOTAL Ownership			2,440,202	2,440,202		2,440,202	60,517	2,500,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,201	468,404	610,605		610,605		610,605			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			780,229	780,229		780,229		780,229			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		142,201	1,248,633	1,390,834		1,390,834		1,390,834			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,402,836	897,371	6,685,019	13,985,226		13,985,226	(364,578)	13,620,648			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	(834,858)	30		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	(1,000)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,073)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(225,560)	36		24
25	Fund Raising, Advertising and Promotional	(21,100)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,472)	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)	\$ (1,096,063)		\$	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)	740,475		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 740,475		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (355,588)		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	\$ (8,990)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
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45				45
46				46
47				47
48				48
49	Total	(8,990)		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	\$ 1,463,569	Kensington Place Property		\$	(1,463,569)	1
2	V	32	Interest		Kensington Place Property		1,467,319	1,467,319	2
3	V	26	Insurance		Kensington Place Property		41,441	41,441	3
4	V	30	Depreciation		Kensington Place Property		1,113,493	1,113,493	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			\$ 1,463,569			\$ 2,622,253	\$ * 1,158,684	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 708,470	Jade Financial Services		\$	(708,470)	15
16	V	21	Office		Jade Financial Services		34,230	34,230	16
17	V	19	Professional Fees		Jade Financial Services		126,018	126,018	17
18	V	5	Utilities		Jade Financial Services		3,544	3,544	18
19	V	6	Repairs & Maintenance		Jade Financial Services		6,040	6,040	19
20	V	34	Rent		Jade Financial Services		3,692	3,692	20
21	V	21	Clerical Wages		Jade Financial Services		88,529	88,529	21
22	V	27	Allocated Benefits		Jade Financial Services		27,192	27,192	22
23	V	26	Insurance		Jade Financial Services		1,016	1,016	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			\$ 708,470			\$ 290,261	\$ * (418,209)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Kensington Place Nrsrg Rehab								
ID#		0052712						
Report Period Beginning:		01/01/2025						
Ending:		12/31/2025						
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee	Building Co.	Management Co./Home Office	
-Owners of companies must be listed instead of company names.								
-Names of trust beneficiaries must be listed.					Ownership Percentage	Ownership Percentage	Ownership Percentage	
First Name	M.I.	Last Name	City	State				
1	Yechiel	D	Mashiach	Lincolnwood	IL	15.20000		1
2	Elimelech	S	Ray	Lincolnwood	IL	7.40000		2
3	Chaim	Y	Ray	Lincolnwood	IL	7.40000		3
4	Devorah	R	Ray	Lincolnwood	IL	7.40000		4
5	Nechama	M.I.	Ray	Lincolnwood	IL	7.40000		5
6	Malka	R	Mashiach	Lincolnwood	IL	15.20000		6
7	Atied Associates, LLC	0	0	0	0	0.00000		7
8	B&Z Grandchildren Tru	0	0	0	0	6.00000		8
9	Beneficiaries	0	0	0	0	0.00000		9
10	Rebecca	0	Rudolph	Evanston	IL	0.00000		10
11	Michael	0	Rudolph	Evanston	IL	0.00000		11
12	Zahava	0	Vales	Evanston	IL	0.00000		12
13	Rabban	0	Vales	Evanston	IL	0.00000		13
14	Natan	0	Vales	Deerfield	IL	0.00000		14
15	Amidei	0	Vales	Deerfield	IL	0.00000		15
16	Cary	0	Silvers	Evanston	IL	0.00000		16
17	Jonathan	0	Silvers	Highland Park	IL	0.00000		17
18	Jacob	0	Silvers	Highland Park	IL	0.00000		18
19	Noam	0	Rothner	Teaneck	NJ	0.00000		19
20	Yonit	0	Rothner	Teaneck	NJ	0.00000		20
21	Hanna	0	Levine	Skokie	IL	0.00000		21
22	Nathan	0	Levine	Evanston	IL	0.00000		22
23	Nathan & Shirley Rothn	0	0	0	0	6.00000		23
24	Beneficiaries	0	0	0	0	0.00000		24
25	Melisa	0	Rothner	Skokie	IL	0.00000		25
26	Daniel	0	Rothner	Teaneck	NJ	0.00000		26
27	William	0	Rothner	Skokie	IL	0.00000		27
28	Rachel	0	Rothner	Beachwood	OH	0.00000		28
29	0	0	0	0	0	0.00000		29
30	Daniel Rothner Accumu	0	0	0	0	0.00000		30
31	Beneficiaries	0	0	0	0	2.00000		31
32	Daniel	0	Rothner	Teaneck	NJ	0.00000		32
33	William RothnerAccum	0	0	0	0	2.00000		33
34	Beneficiaries	0	0	0	0	0.00000		34
35	William	0	Rothner	Skokie	IL	0.00000		35
36	Melissa Rothner Accumu	0	0	0	0	0.00000		36
37	Beneficiaries	0	0	0	0	2.00000		37
38	Melissa	0	Rothner	Skokie	IL	0.00000		38
39	Rachel Rothner Accumu	0	0	0	0	2.00000		39
40	Rachel	0	Rothner	Beachwood	OH	0.00000		40
41	Adam Vales Accumulati	0	0	0	0	2.00000		41
42	Adam	0	Vales	Deerfield	IL	0.00000		42
43	Kathryn Vales Accumul	0	0	0	0	2.00000		43
44	kathryn	0	Vales	Highland park	IL	0.00000		44
45	Kimberly Vales Accumu	0	0	0	0	2.00000		45
46	Kimberly	0	Vales	Highland Park	IL	0.00000		46
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Facility Name & ID Number

Kensington Place Nrsg Rehab

0052712

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 2/31/2025

()

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	21	Office	Number of Beds	1,231	10	\$ 271,852	\$ 155	\$ 34,230	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830	155	126,018	2
3	5	Utilities	Number of Beds	1,231	10	28,149	155	3,544	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967	155	6,040	4
5	34	Rent	Number of Beds	1,231	10	29,319	155	3,692	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	88,529	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961	155	27,192	7
8	26	Insurance	Number of Beds	1,231	10	8,068	155	1,016	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,305,240	\$ 703,094	\$ 290,261	25

Ending: 2/31/2025

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	The Huntington National Bank		X	Mortgage			\$ 16,000,000	\$ 15,978,998			\$ 1,467,319	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	CIBC		X	Working Capital				1,050,000			81,485	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 16,000,000	\$ 17,028,998			\$ 1,548,804	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 16,000,000	\$ 17,028,998			\$ 1,548,804	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.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kensington Place Nrsg Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052712

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-34-119-001-0000	LTC Property	\$ 160,461.83	\$ 160,461.83
2. 17-34-119-002-0000	LTC Property	\$ 27,270.00	\$ 27,270.00
3. 17-34-119-003-0000	LTC Property	\$ 267,962.25	\$ 267,962.25
4. 17-34-119-004-0000	LTC Property	\$ 25,690.93	\$ 25,690.93
5. 17-34-119-005-0000	LTC Property	\$ 32,006.44	\$ 32,006.44
6. 17-34-119-006-0000	LTC Property	\$ 32,006.44	\$ 32,006.44
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 545,397.89	\$ 545,397.89

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,293 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,000	1995	\$ 100,000	1
2					2
3	TOTALS	51,000		\$ 100,000	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	155		1995	1971	\$ 4,046,250	\$	27.5	\$ 101,156	\$ 101,156	\$ 1,473,260
5										
6										
7										
8										
	Improvement Type**									
9	Various		1987		8,296		20			8,296
10	Various		1988		11,646		20			11,646
11	Various		1989		5,250		20			5,250
12	Various		1990		7,780		20			7,780
13	Various		1991		16,578		20			16,578
14	Various		1992		17,269		20			17,269
15	Various		1993		21,968		20			21,968
16	Various		1994		13,356		20			13,356
17	Various		1995		12,270		20			12,270
18	Various		1996		15,797		20			15,797
19	Various		1997		7,187		20			7,187
20	Various		1998		17,815		20			17,815
21	Various		1999		6,043		20			6,043
22	Various		2000		235,020		20			235,020
23	Various		2001		61,023		20			61,023
24	Various		2002		236,588		20			236,588
25	Various		2003		110,588		20			110,588
26	Various		2004		98,820		20			98,820
27	Various		2005		1,500		20	75	75	1,500
28	Various		2006		18,167		20	910	910	18,167
29	Various		2007		7,963		20	398	398	7,564
30	Various		2008		12,185		20	609	609	10,965
31	Various		2009		10,849		20	542	542	9,219
32	Various		2010		87,696		20	4,385	4,385	70,158
33	Various		2011		66,198		20	3,310	3,310	49,649
34	Various		2012		162,288		20	8,114	8,114	113,600
35	Various		2013		55,948		20	2,797	2,797	36,364
36	Various		2014		50,487		20	2,524	2,524	30,290

*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	Various	2016	\$ 389,525	\$	20	\$ 19,477	\$ 19,477	\$ 194,767	37
38	Various	2017	124,803		20	6,242	6,242	54,131	38
39	Various	2018	64,025		20	3,201	3,201	25,609	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)		\$ 6,001,178	\$		\$ 153,740	\$ 153,740	\$ 2,998,537	70

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

Facility Name & ID Number Kensington Place Nrsg Rehab

0052712

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,001,178	\$		\$ 153,740	\$ 153,740	\$ 2,998,537	1
2	Elevator Serviced	2019	5,289		20	264	264	1,849	2
3	Backflow Prevention Work	2019	8,250		20	413	413	2,890	3
4	Upgrade Refrigeration	2019	6,313		20	316	316	2,211	4
5	Electrical work- Replace Breaker	2019	3,300		20	165	165	1,155	5
6	Electrical Work- Install New Breaker	2019	8,500		20	425	425	2,975	6
7	New Sprinkler System	2019	11,554		20	578	578	4,045	7
8	Roof repair- rubber & membrane	2019	5,200		20	260	260	1,820	8
9	Broken Sink Line Piping Repair-Kitchen Greasetrap	2019	3,500		20	175	175	1,225	9
10	Repair & welding on Elevator #2	2019	3,692		20	185	185	1,294	10
11	Nursing Station build In Cabinets- panel and Tops	2020	21,748		20	1,087	1,087	6,522	11
12	New Hot water Tank Boiler room	2020	7,900		20	395	395	2,370	12
13	Generator repair Engine Thermostat Radiator Cooling System	2020	2,739		20	137	137	822	13
14	generator repair- Exhaust Insulation	2020	3,908		20	195	195	1,170	14
15	Hydro Jet System-Brnach line/Pipe fittings- Acros Facility	2020	2,800		20	140	140	840	15
16	Fire Alarm Panel/Annunciator/Communicator-Whole facility	2020	3,458		20	173	173	1,038	16
17	Fire System Installation	2021	21,944		20	1,097	1,097	5,485	17
18	Replace radiator	2021	7,445		20	372	372	1,860	18
19	Interior Painting-3rd floor walls, trims, etc	2021	71,500		20	3,575	3,575	17,875	19
20	Install canopy Lighting Fixtures(Exterior)	2021	27,215		20	1,361	1,361	6,805	20
21	Nursing Station Unit	2021	15,800		20	790	790	3,950	21
22	Door Repair	2021	2,567		20	128	128	640	22
23	Replace Safety Processor and Boards On Rlevator	2021	8,744		20	437	437	2,697	23
24	Security System 45 cameras	2022	17,232		20	862	862	3,448	24
25	Paint 3rd floor-Patient rooms and bathrooms, hallway and cabinet	2022	111,200		20	5,560	5,560	22,240	25
26	Roof repair- rubber & Membrane Northeast Corner	2022	7,500		20	375	375	1,500	26
27	Paint Basement, Kitchen Doors and window frames	2022	62,000		20	3,100	3,100	12,400	27
28	Furnish and Install new sewer pipe	2022	6,500		20	325	325	1,300	28
29	Renovations Electrical Work, lighting, Tile Flooring Shower room	2022	160,666		20	8,033	8,033	33,107	29
30	Paint Patient Rooms, Hallway, Dining room, Shower room	2022	112,200		20	5,610	5,610	22,440	30
31	New water Heater-Kitchen/Laundry	2022	14,900		20	745	745	2,980	31
32	Replace disconnect switch on Elevator #1	2022	3,600		20	180	180	720	32
33	Replace Electrical disconnect Switch on Circulating pump	2022	2,680		20	134	134	536	33
34	TOTAL (lines 1 thru 33)		\$ 6,753,022	\$		\$ 191,332	\$ 191,332	\$ 3,170,746	34

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,753,022	\$		\$ 191,332	\$ 191,332	\$ 3,170,746	1
2	Furnish & Install New sewer Pipe in basement	2022	3,000		20	150	150	600	2
3	Install New Gaf Ruberoid over Old roof	2023	33,000		20	1,650	1,650	4,950	3
4	Replace the Failed Water Heater	2023	13,246		20	662	662	1,986	4
5	Replace 2-3 feet of PVC Pipe	2023	5,800		20	290	290	870	5
6	Repave entire parking lot and regrade the lot also replaced	2023	252,993		20	12,650	12,650	37,452	6
7	Handicap ramp in front of building								7
8	Replac3e Auxilary Relay Board on elevator 1	2024	9,317		20	466	466	932	8
9	Awning	2025	10,525		15	702	702		9
10	Wels a New Hatch Steel Roof Door	2025	3,000		15	200	200		10
11	Disassemble Fire Damper,Clean & Reassemble	2025	27,902		15				11
12	Architectual Drawings	2025	5,156		15				12
13	Install Meter in Generator	2025	6,299		15				13
14	Repair Backflow	2025	3,375		15				14
15	Install New Ventillator Exhaust Fan	2025	8,550		15				15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Financial Statement Depreciation			1,113,493			(1,113,493)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,135,185	\$ 1,113,493		\$ 208,103	\$ (905,391)	\$ 3,217,536	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$705,334	\$	\$70,533	\$70,533	10	\$543,842	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	109,578					109,578	73
74								74
75	TOTALS	\$814,912	\$	\$70,533	\$70,533		\$653,420	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)	\$8,050,097	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,113,493	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$278,636	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(834,858)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,870,956	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Jade				3,692			6
7	TOTAL				\$3,692			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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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

* 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	\$

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)	\$			

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	

(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.

(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	\$		\$ 176,040	\$		\$ 176,040	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			84,336			84,336	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			208,028			208,028	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				69,766		69,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					72,435		72,435	12
13	Other (specify):									13
14	TOTAL			\$		\$ 468,404	\$ 142,201		\$ 610,605	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.

Facility Name & ID Number	Kensington Place Nrsg Rehab
--------------------------------------	------------------------------------

0052712

Report Period Beginning: 01/01/2025

Ending:

12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025

____ (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 115,337	\$ 115,337	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,089,195	3,089,195	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	358,433	358,433	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related	4,797,919	4,797,919	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,360,884	\$ 8,360,884	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		490,074	13
14	Buildings, at Historical Cost		10,622,058	14
15	Leasehold Improvements, at Historical Cost	1,953,716	1,953,716	15
16	Equipment, at Historical Cost	391,171	904,039	16
17	Accumulated Depreciation (book methods)	(770,231)	(4,481,873)	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): Deposits	117,224	117,224	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,691,880	\$ 9,605,238	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,052,764	\$ 17,966,122	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,039,756	\$ 2,039,756	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,050,000	1,050,000	29
30	Accrued Salaries Payable	625,317	625,317	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,656	13,656	31
32	Accrued Real Estate Taxes(Sch.IX-B)	556,306	556,306	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,285,035	\$ 4,285,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,978,998	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)	\$	\$ 15,978,998	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,285,035	\$ 20,264,033	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,765,729	\$ (2,297,911)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,050,764	\$ 17,966,122	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,265,121	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,265,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,505,877	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	(5,269)	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)	\$ 1,500,608	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)	\$ 5,765,729	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Kensington Place Nrsg Rehab

0052712

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,238,773	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,238,773	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		252,330	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 252,330	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,491,103	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,928,366	31
32	Health Care	4,987,681	32
33	General Administration	3,238,143	33
	B. Capital Expense		
34	Ownership	2,440,202	34
	C. Ancillary Expense		
35	Special Cost Centers	610,605	35
36	Provider Participation Fee	780,229	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,985,226	40
41	Income before Income Taxes (line 30 minus line 40)**	1,505,877	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,505,877	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,675,625.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	9,029,418.00	45
46	MMAI-Medicaid is the Primary Payer	496,461.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	88,775.00	48
49	Medicare Part A	3,480,688.00	49
50	Other-(specify) Medicare-B	162,026.00	50
51	Other-(specify) Insurance	305,780.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,238,773	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	1,952	2,120	\$ 140,066	\$ 66.07	1
2	Assistant Director of Nursing	488	995	47,507	47.75	2
3	Registered Nurses	11,656	12,627	586,752	46.47	3
4	Licensed Practical Nurses	32,474	34,980	1,498,222	42.83	4
5	CNAs & Orderlies	62,834	68,863	1,789,979	25.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,983	2,071	43,465	20.99	9
10	Activity Assistants	4,981	5,602	112,749	20.13	10
11	Social Service Workers	10,233	11,226	300,567	26.77	11
12	Dietician					12
13	Food Service Supervisor	1,957	2,127	72,441	34.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,987	17,351	366,782	21.14	15
16	Dishwashers					16
17	Maintenance Workers	5,728	6,370	179,685	28.21	17
18	Housekeepers	13,486	14,810	294,939	19.91	18
19	Laundry	5,530	6,235	128,186	20.56	19
20	Administrator	2,992	3,040	198,272	65.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,078	11,466	481,910	42.03	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	1,737	1,909	42,772	22.41	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,302	2,462	118,542	48.15	33
34	TOTAL (lines 1 - 33)	186,398	204,254	\$ 6,402,836 *	\$ 31.35	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,657	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant	Monthly	2,306	10-3	37
38	Nurse Consultant	Monthly	113,664	10-3	38
39	Pharmacist Consultant	Monthly	10,355	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)		\$ 149,982		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Yechiel Mashiach	Administrator	15.2	\$ 112,000	Workers' Compensation Insurance		\$ 46,695	IDPH License Fee	\$	
Julie Amico	Asst Adm	0	86,272	Unemployment Compensation Insurance		31,415	Advertising: Employee Recruitment	20,552	
				FICA Taxes		496,177	Health Care Worker Background Check	8,990	
				Employee Health Insurance			(Indicate # of checks performed _____)		
				Employee Meals		315,427	Patient Background Checks	3,110	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	26,970	
							Netsmart	3,828	
							RADAR	2,500	
							Various	17,963	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 198,272				Less: Public Relations Expense	()	
							PAC and Lobbying payments	(8,990)	
							All non-allowable advertising	()	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	17,980
	17,980 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)	8,990
	8,990 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	26,970
	26,970 Total
- (5)

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

\$ 29,875 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.

\$ 780,229

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

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

No If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

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

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

\$ Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

Travel and Transportation

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

No If YES, attach a complete explanation.

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

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

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

d. Have vehicle usage logs been maintained?

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

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

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

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

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

Firm Name: 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.