

		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: 0010637

Facility Name: LaSalle County Nursing Home

Address: 1380 North 27th Road Ottawa 61350

County: LaSalle

Telephone Number: (815) 433-0476 Fax # (815)433-7141

HFS ID Number:

Date of Initial License for Current Owners: 1945

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X

County

Other

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

Name: Amanda Springborn Telephone Number: (314) 925-3838

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 12/1/2024 to 11/30/2025 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)

(Title)

(Signed)

(Date)

Paid Preparer

(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 LaSalle County Nursing Home # 0010637 Report Period Beginning: 12/1/2024 Ending: 11/30/2025

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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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						857		857	8
9	SNF/PED									9
10	ICF	4,921	3,465	3,941		8,802		254	21,383	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,921	3,465	3,941		8,802	857	254	22,240	14

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

77.13%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒ Note : Non-allowable costs have been eliminated in Schedule V, Column

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 11/01/1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 79

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 11/30/2025 Fiscal Year: 11/30/2025

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

Facility Name & ID Number		LaSalle County Nursing Home				#	0010637	Report Period Beginning:		12/1/2024	Ending:		11/30/2025
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			649,884	649,884		649,884		649,884			1	
2	Food Purchase											2	
3	Housekeeping	267,861	23,541		291,402		291,402		291,402			3	
4	Laundry	159,241	11,164		170,405		170,405		170,405			4	
5	Heat and Other Utilities			153,933	153,933		153,933		153,933			5	
6	Maintenance	175,942	11,784	368,362	556,088		556,088	(110,607)	445,481			6	
7	Other (specify):*											7	
8	TOTAL General Services	603,044	46,489	1,172,179	1,821,712		1,821,712	(110,607)	1,711,105			8	
	B. Health Care and Programs												
9	Medical Director			28,500	28,500		28,500		28,500			9	
10	Nursing and Medical Records	2,855,245	214,047	645,346	3,714,638		3,714,638		3,714,638			10	
10a	Therapy	48,041			48,041		48,041		48,041			10a	
11	Activities	169,260	1,682	1,400	172,342		172,342		172,342			11	
12	Social Services	210,352		2,064	212,416		212,416		212,416			12	
13	CNA Training											13	
14	Program Transportation											14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	3,282,898	215,729	677,310	4,175,937		4,175,937		4,175,937			16	
	C. General Administration												
17	Administrative	91,022			91,022		91,022	42,268	133,290			17	
18	Directors Fees											18	
19	Professional Services			34,132	34,132		34,132		34,132			19	
20	Dues, Fees, Subscriptions & Promotions			14,411	14,411		14,411	(455)	13,956			20	
21	Clerical & General Office Expenses	158,579	20,998	60,669	240,246		240,246	48,502	288,748			21	
22	Employee Benefits & Payroll Taxes			1,045,102	1,045,102		1,045,102	649,005	1,694,107			22	
23	Inservice Training & Education											23	
24	Travel and Seminar			1,377	1,377		1,377		1,377			24	
25	Other Admin. Staff Transportation			167	167		167		167			25	
26	Insurance-Prop.Liab.Malpractice							162,778	162,778			26	
27	Other (specify):*											27	
28	TOTAL General Administration	249,601	20,998	1,155,858	1,426,457		1,426,457	902,098	2,328,555			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,135,543	283,216	3,005,347	7,424,106		7,424,106	791,491	8,215,597			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 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	
	D. Ownership											
30	Depreciation							257,979	257,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,469	4,469		4,469		4,469			35
36	Other (specify):*											36
37	TOTAL Ownership			4,469	4,469		4,469	257,979	262,448			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,984	425,873	462,857		462,857		462,857			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,878	129,878		129,878		129,878			42
43	Other (specify):* Non-Allowable Cos			39,668	39,668		39,668	(39,668)				43
44	TOTAL Special Cost Centers		36,984	595,419	632,403		632,403	(39,668)	592,735			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,135,543	320,200	3,605,235	8,060,978		8,060,978	1,009,802	9,070,780			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	(19,805)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	254,701	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				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	(17,680)	43		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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(131,329)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 85,887		\$	30

BHF USE ONLY							
48		49		50		51	

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)	923,915		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 923,915		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,009,802		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (455)	20	1
2				2
3	Capitalized R&M	(131,109)	6	3
4	Depreciation for R&M Capitalized	3,278	30	4
5	Marketing	(2,183)	43	5
6	Miscellaneous Income	(860)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(131,329)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership Listing-1		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	IMRF	\$	LaSalle County, Illinois		\$ 367,236	\$ 367,236	1
2	V	22	FICA		LaSalle County, Illinois		262,991	262,991	2
3	V	6	County Maintenance		LaSalle County, Illinois		20,502	20,502	3
4	V	17	County Treasurer		LaSalle County, Illinois		3,092	3,092	4
5	V	17	County Board Office		LaSalle County, Illinois		17,018	17,018	5
6	V	17	County Attorney		LaSalle County, Illinois		12,300	12,300	6
7	V	17	County Auditor		LaSalle County, Illinois		5,263	5,263	7
8	V	17	County Courthouse		LaSalle County, Illinois		4,595	4,595	8
9	V	21	County Human Resource		LaSalle County, Illinois		29,219	29,219	9
10	V	21	County IT Department		LaSalle County, Illinois		20,143	20,143	10
11	V	22	County Workers Comp		LaSalle County, Illinois		18,778	18,778	11
12	V	26	County Liability Insurance		LaSalle County, Illinois		162,778	162,778	12
13	V								13
14	Total			\$			\$ 923,915	\$ * 923,915	14

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

STATE OF ILLINOIS

Ownership Listing-1

LaSalle County Nursing Home

ID#0010637

Report Period Beginning:12/1/2024

Ending:11/30/2025

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

City

State

City

State

City

State

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1StephenAubryMarsellesIL0.000000.000000.0000001

2JamesBaileyOttawaIL0.000000.000000.0000002

3JillBernalPeruIL0.000000.000000.0000003

4RonaldBlueStreatorIL0.000000.000000.0000004

5KathyBrightSheridanIL0.000000.000000.0000005

6WilliamBrownUticaIL0.000000.000000.0000006

7TinaBuschTonicaIL0.000000.000000.0000007

8BrianDoseOttawaIL0.000000.000000.0000008

9CraigEmmettOttawaIL0.000000.000000.0000009

10NancyEurichStreatorIL0.000000.000000.00000010

11RayGatzaPeruIL0.000000.000000.00000011

12MichaelMcEmeryMarsellesIL0.000000.000000.00000012

13JoanneMcNallyMendotaIL0.000000.000000.00000013

14Ali BraboyBraboyLaSalleIL0.000000.000000.00000014

15ThomasMillerOttawaIL0.000000.000000.00000015

16JoeOsecpinski Jr.PeruIL0.000000.000000.00000016

17CathyOwensSandwichIL0.000000.000000.00000017

18KindraPottfingerSheridanIL0.000000.000000.00000018

19JamesReidSandwichIL0.000000.000000.00000019

20WalterRoach Jr.StreatorIL0.000000.000000.00000020

21JosephSavitchLaSalleIL0.000000.000000.00000021

22MattSlagerStreatorIL0.000000.000000.00000022

23GarySmallUticaIL0.000000.000000.00000023

24DouglasStockleyEarvilleIL0.000000.000000.00000024

25ThomasTempletonPeruIL0.000000.000000.00000025

26DavidTorresOglesbyIL0.000000.000000.00000026

27DouglasTragerOttawaIL0.000000.000000.00000027

28TomWalshOttawaIL0.000000.000000.00000028

29ArrattaZaniecekiOttawaIL0.000000.000000.00000029

30313233343536373839404142434445464748495051525354555657585960616263646566676869707172737475

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	N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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23								23
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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	N/A								\$		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

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				N/A			\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12/1/2024 Ending: 1/30/2025

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 County of LaSalle
Street Address 707 Etna Road
City / State / Zip Code Ottawa, Illinois 61350
Phone Number (815)433-0476
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22	IMRF	Direct Cost			\$	\$		\$ 367,236	1
2	22	FICA	Direct Cost						262,991	2
3	6	County Maintenance	Time Spent	6,240		246,020	246,020	520	20,502	3
4	17	County Treasurer	Time Spent	10,400		309,238	309,238	104	3,093	4
5	17	County Board Office	Time Spent	4,160		136,143	136,143	520	17,018	5
6	17	County Attorney	Time Spent	2,080		123,000	123,000	208	12,300	6
7	17	County Auditor	Time Spent	6,240		157,880	157,880	208	5,263	7
8	17	County Courthouse	Square Footage	127,108		2,049,184		285	4,595	8
9	21	County Human Resource	Time Spent	6,240		233,750	233,750	780	29,219	9
10	21	County IT Department	Time Spent	6,240		241,710	241,710	520	20,143	10
11	22	County Workers Comp	Direct Cost						18,778	11
12	26	County Liability Insurance	Direct Cost						162,778	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					\$ 3,496,925	\$ 1,447,741		\$ 923,915	25

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$		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.)		2024	\$		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.)			\$		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.		Alloc. Fr. Mgmt. Co.			
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.			\$		7
Assessed Value from Real Estate Tax Bill:		2024		8	
Real Estate Tax Bill for Calendar Year:		2020		9	
		2021		10	
		2022		11	
		2023		12	
		2024		13	
Facility does not pay real estate taxes					

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

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaSalle County Nursing Home COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0010637

CONTACT PERSON REGARDING THIS REPORT Brittany Reynolds

TELEPHONE (815) 617-4250 FAX #: (815) 434-7141

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)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. N/A		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 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: 47,592 **B. General Construction Type:** Exterior Brick Frame Steel Number of Stories 2

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).

None

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease. N/A

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

X If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over.

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

--	--

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1	Land	513,000	1960	\$ 9,950
2				
3	TOTALS	513,000		\$ 9,950

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	79			1969	\$ 9,575	\$		\$		\$ 9,575	4
5				1965	760,000					760,000	5
6				1967	51,675					51,675	6
7				1969	123,087					123,087	7
8				1978	164,927					164,927	8
	Improvement Type**										
9	Various			1966	4,643		20			4,643	9
10	Various			1968	35,441		20			35,441	10
11	Various			1970	12,456		20			12,456	11
12	Various			1971	22,125		20			22,125	12
13	Various			1972	1,487		20			1,487	13
14	Various			1974	985		20			985	14
15	Various			1975	6,391		20			6,391	15
16	Various			1976	24,443		20			24,443	16
17	Various			1977	28,326		20			28,326	17
18	Various			1978	25,471		20			25,471	18
19	Various			1979	40,012		20			40,012	19
20	Various			1980	54,262		20			54,262	20
21	Various			1981	31,671		20			31,671	21
22	Various			1982	289,413		20			289,413	22
23	Various			1983	23,135		20			23,135	23
24	Various			1984	17,164		20			17,164	24
25	Various			1985	38,629		20			38,629	25
26	Various			1986	182,002		20			182,002	26
27	Various			1987	62,084		20			62,084	27
28	Various			1989	43,548		20			43,548	28
29	Various			1990	269,784		20			269,784	29
30	Various			1991	36,959		20			36,959	30
31	Various			1992	4,120		20			4,120	31
32	Various			1993	60,542		20			60,542	32
33	Various			1994	104,162		20			104,162	33
34	Various			1995	250,524		20			250,524	34
35	Various			1996	87,629		20			41,692	35
36	Various			1998	169,013		20			169,013	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	1999	\$ 26,004	\$	20	\$	\$	\$ 26,004	37
38	Various	2000	621,990		20			621,990	38
39	Various	2001	31,418		20			22,718	39
40	Various	2002	98,701		20			98,701	40
41	Various	2004	12,126		20			12,126	41
42	Various	2005	16,662		20	310	310	16,662	42
43	Various	2006	3,360		20			3,360	43
44	Various	2007	2,668		20			2,668	44
45	Various	2008	65,268		20	1,364	1,364	62,546	45
46	Various	2009	290,785		20	14,539	14,539	157,305	46
47	Various	2010	140,811		20	7,041	7,041	58,211	47
48	Various	2011	149,897		20	8,776	8,776	103,227	48
49	Various	2012	134,861		20	6,743	6,743	94,246	49
50	Various	2013	84,700		20	4,235	4,235	55,774	50
51	Various	2014	321,066		20	16,053	16,053	192,639	51
52	Various	2015	162,768		20	8,138	8,138	88,484	52
53	Various	2016	583,353		20	29,168	29,168	291,677	53
54	Various	2017	1,748,362		20	87,418	87,418	813,421	54
55	Various	2018	248,679		20	12,434	12,434	99,472	55
56	Various	2019	113,729		20	5,686	5,686	39,805	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)		\$ 7,892,893	\$		\$ 201,905	\$ 201,905	\$ 5,850,784	70

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

Facility Name & ID Number LaSalle County Nursing Home

0010637

Report Period Beginning:

12/1/2024

Ending:

11/30/2025

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		\$ 7,892,893	\$		\$ 201,905	\$ 201,905	\$ 5,850,784	1
2	Sewage Pump	2020	6,900		20	345	345	2,070	2
3	Generator Repair	2020	2,591		20	130	130	778	3
4	Repair Well Controls	2020	9,819		20	491	491	2,946	4
5	Well House Wiring	2020	2,950		20	148	148	886	5
6	Dietary Piping	2020	3,709		20	185	185	1,112	6
7	Install New Sola Board For Boiler	2020	3,901		20	195	195	1,170	7
8	Fuel Tank	2020	3,540		20	177	177	1,062	8
9	Gaskets Repair	2021	4,588		20	229	229	1,147	9
10	Sprinkler Heads	2021	4,612		20	231	231	1,153	10
11	Boiler Replacement Of Gaskets & Ignitors	2021	5,522		20	276	276	1,104	11
12	Installation Of New Trane Air Conditioner	2022	2,995		20	150	150	599	12
13	Installation Of Train Air Handler	2022	3,800		20	190	190	760	13
14	Security Cameras	2023	21,483		20	1,074	1,074	3,222	14
15	Rebuild Water Softener	2023	5,671		20	284	284	851	15
16	Bearing Assembly & Pump	2023	3,918		20	196	196	588	16
17	Hvac Repair	2023	3,929		20	196	196	589	17
18	Install Mixing Valve On Boiler	2023	5,185		20	259	259	778	18
19	A/C For Laundry Room	2023	14,881		20	744	744	2,232	19
20	Backflow Repair	2023	2,738		20	137	137	411	20
21	Ac Units Motors Replaced	2023	4,219		20	211	211	633	21
22	Courtyard Sidewalk Repair	2023	28,554		20	1,428	1,428	4,283	22
23	Pumphouse generator install	2024	29,489		20	1,474	1,474	2,211	23
24	HVAC-install pump assembly	2024	7,521		20	376	376	564	24
25	Gas actuator for boiler #5	2024	3,683		20	184	184	276	25
26	Outside light poles	2024	4,144		20	207	207	311	26
27	Flooring replacement 2 bathrooms	2024	9,945		20	497	497	746	27
28	Water heater valves, radiator hoses, fan belt replacement	2024	3,257		20	164	164	245	28
29	Demo concrete floor and replace pipes	2024	6,142		20	307	307	461	29
30	Replacement (2) compressor	2025	16,654		20	416	416	416	30
31	Kitchen Electrical panel replacement	2025	28,875		20	722	722	722	31
32	Pipe replacement crawl space	2025	6,854		20	171	171	171	32
33	South Kitchen exhaust fan	2025	4,979		20	124	124	124	33
34	TOTAL (lines 1 thru 33)		\$ 8,159,941	\$		\$ 213,823	\$ 213,823	\$ 5,885,405	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,159,941	\$		\$ 213,823	\$ 213,823	\$ 5,885,405	1
2	Touchpad Exit controller with speaker		3,245			81	81	81	2
3	Bathroom floor quartz		3,800			95	95	95	3
4	Delayed Egress project doors		4,949			124	124	124	4
5	Ceiling Fan Installs		10,885			272	272	272	5
6	Parking lot lights		26,395			660	660	660	6
7	FOB System installation for keypads		4,665			117	117	117	7
8	Quartz Epoxy in 2 showers		3,200			80	80	80	8
9	Parking lot asphalt repavement		16,608			415	415	415	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	TOTAL (lines 1 thru 33)		\$ 8,233,688	\$		\$ 215,667	\$ 215,667	\$ 5,887,249	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	\$276,164	\$	\$27,173	\$27,173	10	\$276,164	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	732,054				10	732,054	73
74								74
75	TOTALS	\$1,008,218	\$	\$27,173	\$27,173		\$1,008,218	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		2005 Ford Van	2005	\$58,741	\$	\$	\$	5	\$58,741	76
77		Dodge Grand Caravan	2006	15,775				5	15,775	77
78		2015 Ford F-350	2014	34,764				5	34,764	78
79		See 13A		77,837		15,139	15,139	5	47,665	79
80	TOTALS			\$187,117	\$	\$15,139	\$15,139		\$156,945	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)	\$9,438,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$257,979	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$257,979	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,052,412	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	Parking Improvements - 1972	\$11,751	\$	\$	86
87	Improvement G2 - 1974	4,900			87
88	Auto - 1994	3,600			88
89					89
90					90
91	TOTALS	\$20,251	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

Facility Name:LaSalle County Nursing Home

IDPH License ID Number:0010637

Fiscal Year End:11/30/2025

Schedule 13A

XI. Ownership Costs

Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Bus Repairs	2020	2,858		143	-	5	858
	Bus Repairs	2022	3,698		740	-	5	2,959
	Repairs to Ford	2022	5,399		1,080	-	5	4,320
	2023 Chrysler Voyage	2023	65,882		13,176	-	5	39,528
						-	5	
						-		
						-		
TOTAL			77,837	-	15,139	-		47,665

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

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

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

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

9. Option to Buy: YESNO

Terms:

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$4,469

Description: Water system \$410, Postage machine \$346, Copier rental \$3,713

(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

It is the policy of this facility to only hire certified nurses aides.
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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,915	425,873		5,915	425,873	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				36,984		36,984	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			\$	5,915	\$ 425,873	\$ 36,984	5,915	\$ 462,857	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,933,507	\$ 2,933,507	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	147,185	147,185	3
4	Supply Inventory (priced at)	33,837	33,837	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest-Investments</u>	11,689	11,689	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,126,218	\$ 3,126,218	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,950	9,950	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,770,147	8,233,688	15
16	Equipment, at Historical Cost	1,252,532	1,195,335	16
17	Accumulated Depreciation (book methods)	(6,335,930)	(7,052,412)	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): <u>See Attached</u>	2,491,792	2,491,792	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,188,491	\$ 4,878,353	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,314,709	\$ 8,004,571	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,941	\$ 184,941	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,953	10,953	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	489,788	489,788	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 685,682	\$ 685,682	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	<u>See Attached</u>	1,807,095	1,807,095	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,807,095	\$ 1,807,095	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,492,777	\$ 2,492,777	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,821,932	\$ 5,511,794	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,314,709	\$ 8,004,571	48

*(See instructions.)

Facility Name:LaSalle County Nursing Home

IDPH License ID Number:0010637

Fiscal Year End:11/30/2025

Schedule 17A

XV. Balance Sheet

Line 23 Other Long-Term Assets (specify):

Description	Operating	After
		Consolidation
013-000-131 Property Taxes Receivable	1,806,218	1,806,218
013-000-298 Transfer in/out account	685,574	685,574
Total - Line 23	2,491,792	2,491,792
	-	-

XV. Balance Sheet

Line 43 Other Long-Term Liabilities (specify):

Description	Operating	After
		Consolidation
013-000-231 Deferred Revenue	1,757,517	1,757,517
013-000-231 Deferred Patient Revenue	49,578	49,578
013-000-293 Revenue Control	-	-
013-000-294 Expense Control	-	-
Total - Line 36	1,807,095	1,807,095
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,890,915	1
2	Restatements (describe):		2
3	Prior period adjustment	(369,652)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,521,263	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,669	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)	\$ 300,669	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)	\$ 4,821,932	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LaSalle County Nursing Home

0010637

Report Period Beginning: 12/1/2024

Ending: 11/30/2025

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	\$ 5,930,471	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,930,471	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,410	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 95,410	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***	101,405	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 101,405	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Schedule 19A</u>	2,234,361	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,234,361	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,361,647	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,821,712	31
32	Health Care	4,175,937	32
33	General Administration	1,426,457	33
	B. Capital Expense		
34	Ownership	4,469	34
	C. Ancillary Expense		
35	Special Cost Centers	502,525	35
36	Provider Participation Fee	129,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,060,978	40
41	Income before Income Taxes (line 30 minus line 40)**	300,669	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 300,669	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,479,694.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,041,890.00	45
46	MMAI-Medicaid is the Primary Payer	1,185,019.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,055,422.00	48
49	Medicare Part A	168,446.00	49
50	Other-(specify)		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)	\$ 5,930,471	56

Facility Name: LaSalle County Nursing Home
IDPH License ID Number: 0010637
Fiscal Year End: 11/30/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

	Description	Amount
013-000-301001	Tax Levy	1,765,100
013-000-313028	NURSING SERVICES	(50)
013-000-350001	Miscellaneous Income	860
013-000-350003	QIP Incentive	82,746
013-000-399001	Fund Balance Use	(1,371)
013-000-390000-243	Transfer from 016 Insurance	387,076
	Total - Line 28	2,234,361
		-

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	1,851	\$ 83,939	\$ 45.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,547	11,167	463,279	41.49	3
4	Licensed Practical Nurses	6,691	5,955	274,419	46.08	4
5	CNAs & Orderlies	76,107	67,735	1,852,892	27.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,131	1,897	48,041	25.32	8
9	Activity Director	2,080	1,851	46,411	25.07	9
10	Activity Assistants	6,925	6,163	122,849	19.93	10
11	Social Service Workers	4,989	4,441	210,352	47.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,252	5,902	175,942	29.81	17
18	Housekeepers	12,807	14,390	267,861	18.61	18
19	Laundry	4,468	5,020	159,241	31.72	19
20	Administrator	1,851	2,080	91,022	43.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,341	2,631	158,579	60.27	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	712	800	38,626	48.28	31
32	Other Health Care(specify)	1,565	1,759	64,009	36.39	32
33	Other(specify) MDS	1,851	2,080	78,081	37.54	33
34	TOTAL (lines 1 - 33)	144,397	135,722	\$ 4,135,543 *	\$ 30.47	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	\$ 649,884	1(3)	35
36	Medical Director	Monthly	28,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,076	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	21	1,400	11(3)	44
45	Social Service Consultant	29	2,064	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	\$ 688,924		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,501	\$ 75,048	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16,325	563,222	10(3)	52
53	TOTAL (lines 50 - 52)	17,826	\$ 638,270		53

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

** 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

LEADING AGE

3,045

3,045

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.

LEADING AGE

455

455

Total
- (4)

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

LEADING AGE

3,500

3,500

Total
- (5)

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

\$

26,785

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.

\$

129,878

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.

\$

N/A

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?

No

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

\$

N/A

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

100% LN 1

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

No

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

\$

N/A
- (13)

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

Firm Name:

N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

N/A

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