

		FOR BHF USE					

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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: 0054643

Facility Name: Little Village Nrsg Rhb Ctr

Address: 2320 S Lawndale Ave Chicago 60623
Number City Zip Code

County: DuPage

Telephone Number: 773-522-0400 Fax # 773-522-1692

HFS ID Number:

Date of Initial License for Current Owners: 08/01/2017

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider Telephone Number: 847-933-1274
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 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

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 Little Village Nrsg Rhb Ctr # 0054643 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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			1,898		934	1,934	292	5,058	8
9	SNF/PED									9
10	ICF	3,718	26,739						30,457	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,718	26,739	1,898		934	1,934	292	35,515	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.79%

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 08/01/17

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 08/01/17 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 14

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Little Village Nrsrg Rhb Ctr # 0054643 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	476,654	26,199	6,481	509,334		509,334		509,334			1
2	Food Purchase		295,476		295,476		295,476	(108)	295,368			2
3	Housekeeping	447,950	52,228	61,925	562,103		562,103		562,103			3
4	Laundry	100,203	15,371		115,574		115,574		115,574			4
5	Heat and Other Utilities			132,372	132,372		132,372	2,424	134,796			5
6	Maintenance	60,430		66,520	126,950		126,950	4,130	131,080			6
7	Other (specify):*											7
8	TOTAL General Services	1,085,237	389,274	267,298	1,741,809		1,741,809	6,446	1,748,255			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,002,032	125,107	234,754	3,361,893		3,361,893		3,361,893			10
10a	Therapy											10a
11	Activities	168,599	11,466		180,065		180,065		180,065			11
12	Social Services	138,144	1,518		139,662		139,662		139,662			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,308,775	138,091	258,754	3,705,620		3,705,620		3,705,620			16
	C. General Administration											
17	Administrative	125,905		512,751	638,656		638,656	(512,751)	125,905			17
18	Directors Fees											18
19	Professional Services			91,184	91,184		91,184	86,180	177,364			19
20	Dues, Fees, Subscriptions & Promotions			54,956	54,956		54,956	(14,651)	40,305			20
21	Clerical & General Office Expenses	540,454	141,361	180,404	862,219		862,219	54,325	916,544			21
22	Employee Benefits & Payroll Taxes			724,178	724,178		724,178		724,178			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,606	1,606		1,606		1,606			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			388,204	388,204		388,204	695	388,899			26
27	Other (specify):* Allocated Benefits							18,596	18,596			27
28	TOTAL General Administration	666,359	141,361	1,953,283	2,761,003		2,761,003	(367,606)	2,393,397			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,060,371	668,726	2,479,335	8,208,432		8,208,432	(361,160)	7,847,272			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			44,896	44,896		44,896	(11,237)	33,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			426,258	426,258		426,258		426,258			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	2,525	542,525			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			602,765	602,765		602,765	(602,765)				36
37	TOTAL Ownership			1,613,919	1,613,919		1,613,919	(611,477)	1,002,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,134	225,332	288,466		288,466		288,466			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			718,166	718,166		718,166		718,166			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		63,134	943,498	1,006,632		1,006,632		1,006,632			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,060,371	731,860	5,036,752	10,828,983		10,828,983	(972,637)	9,856,346			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	(11,237)	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	(108)	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	(29,627)	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	(602,765)	36		24
25	Fund Raising, Advertising and Promotional	(8,503)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (652,240)		\$	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)	(314,249)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (314,249)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (966,489)		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	\$ (6,148)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,148)		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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 512,751	Java Financial Services		\$	(512,751)	15
16	V	21	Office		Java Financial Services		23,409	23,409	16
17	V	19	Professional Fees		Java Financial Services		86,180	86,180	17
18	V	5	Utilities		Java Financial Services		2,424	2,424	18
19	V	6	Repairs & Maintenance		Java Financial Services		4,130	4,130	19
20	V	34	Rent		Java Financial Services		2,525	2,525	20
21	V	21	Clerical Wages		Java Financial Services		60,543	60,543	21
22	V	27	Allocated Benefits		Java Financial Services		18,596	18,596	22
23	V	26	Insurance		Java Financial Services		695	695	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			\$ 512,751			\$ 198,502	\$ * (314,249)	39

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

VII. RELATED PARTIES

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

	1 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	Abbingtong Village Nursing	Roselle			Jade Financial	Skokie, Ill	Mgmt	1
2	All American Nursing	Chicago						2
3	Hickory Village Nursing	Hickory Hills						3
4	Kensington Place Nursing	Chicago						4
5	Sheridan Village Nursing	Chicago						5
6	Tri-State Village	Lansing						6
7	Wheaton Village Nursing	Wheaton						7
8	Westwood Village Nursing	Chicago						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Jade Financial Services LLC
Street Address 8707 Skokie Blvd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 213-1060
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	21	Office	Number of Beds	1,231	10	\$ 271,852	\$	106	\$ 23,409	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		106	86,180	2
3	5	Utilities	Number of Beds	1,231	10	28,149		106	2,424	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		106	4,130	4
5	34	Rent	Number of Beds	1,231	10	29,319		106	2,525	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	106	60,543	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		106	18,596	7
8	26	Insurance	Number of Beds	1,231	10	8,068		106	695	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		\$ 198,502	25

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													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. \$ 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.)

B. Real Estate Taxes

[illegible]

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 Little Village Nrsg Rhb Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0054643

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. 16-26-105-075-0000	Long Term Property	\$ 27,424.72	\$ 27,424.72
2. 16-26-105-079-0000	Long Term Property	\$ 154,489.66	\$ 154,489.66
3. 16-26-105-080-0000	Long Term Property	\$ 154,652.76	\$ 154,652.76
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 336,567.14	\$ 336,567.14

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: 26,849 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
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 NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2018	8,610		15	574	574	4,626	9
10	Replacement of Front Door			2019	3,063		20	153	153	1,071	10
11	Installation of Sink-2nd Floor Dining Area			2019	3,800		20	190	190	1,320	11
12	Painted 1st Floor & Basement			2019	16,850		20	843	843	5,900	12
13	Replaced Door to Courtyard			2019	6,488		20	324	324	2,269	13
14	Electrical Wiring/Cable/Call Light System			2019	30,818		20	1,541	1,541	10,787	14
15	Built in Pumps/Transformer,Amp,Limit Switch			2019	16,800		20	840	840	5,880	15
16	Copper Water Piping From Basement			2019	33,000		20	1,650	1,650	11,550	16
17	Signage for Corridors			2019	2,925		20	146	146	1,023	17
18	Drywall & Tile Patching to 7 Resident Rooms			2019	3,500		20	175	175	1,225	18
19	Install New Ejector Pump/Mixing Valve			2019	3,300		20	165	165	1,175	19
20	Repairs to Cabling for Passenger Elevator			2019	2,935		20	147	147	1,029	20
21	Metal Pedestrian Door			2020	3,681		20	184	184	1,104	21
22	Flowline/Backflow Precenter			2020	22,225		20	1,111	1,111	6,666	22
23	Fire Alarm System,Devices,Panels-Basement			2020	24,820		20	1,241	1,241	7,446	23
24	Fire Alarm System-Tamper Panel Replacement			2020	4,025		20	201	201	1,206	24
25	Boiler Installation-Ejector Pit,Piping,Gaskets			2020	66,549		20	3,327	3,327	19,962	25
26	45 Feet of Handrails-Exterior Walkways			2020	2,500		20	125	125	750	26
27	Ejector Pit Lids& Piping Repairs-Sump System			2020	3,186		20	159	159	954	27
28	Concrete Work & Piping /Hub Cupling			2020	2,691		20	135	135	810	28
29	Pump & Motor Replacement on Elevator			2020	5,279		20	264	264	1,584	29
30	Boiler Replacement			2020	20,337		20	1,017	1,017	6,102	30
31	Install & Relocate Security Cameras			2020	2,636		20	132	132	660	31
32	Replaced Maglock/Install Siren in Hallway			2020	2,963		20	148	148	740	32
33	Installation of Mop Sink			2021	3,500		20	175	175	875	33
34	New Exterior Deck			2021	78,600		20	3,930	3,930	19,650	34
35	New Lighting on N Exterior Wall			2021	23,900		20	1,195	1,195	5,975	35
36	New Sump Pit Covers			2021	3,988		20	199	199	995	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

Facility Name & ID Number Little Village Nrsg Rhb Ctr

0054643

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	
37	Metal Pedestrian Doors By Boiler & Laundry Rooms	2021	\$ 7,875	\$	20	\$ 394	\$ 394	\$ 1,970	37
38	New Relay, Relay Base, Timer on Elevator	2021	2,560		20	128	128	640	38
39	Plumbing Repairs	2021	6,148		20	307	307	1,535	39
40	Replace Traveling Cable in Elevator	2021	4,609		20	230	230	1,150	40
41	Generator Repairs	2021	2,571		20	129	129	645	41
42	Replace Power Supply Maglocks	2021	3,589		20	179	179	895	42
43	Fire Sprinkler system Repair	2021	2,977		20	149	149	745	43
44	Basement Dining & Kitchen A/C System	2022	16,500		20	825	825	3,300	44
45	Install Panic Device/Spring Hinges West Hallway Door	2022	3,606		20	180	180	720	45
46	Install Panic Devices on Doors Main Entrance & East Wing	2022	6,140		20	307	307	1,228	46
47	Laundry Exhaust Replacement, Adapt Wiring & Flue Pipes	2022	4,070		20	204	204	816	47
48	Repair A/C in S Basement/Install Gauges	2022	2,696		20	135	135	540	48
49	North-Replace Compressor,Filter Drier & Fan Motor	2022	5,256		20	263	263	1,052	49
50	Lower Bldg-Replace Capacitor,Compressor	2022	3,670		20	184	184	736	50
51	Elevator Repair-Install New Motor Starter	2022	3,050		20	152	152	608	51
52	Fire Alarm System-Install Tamper,Smoker & Chime	2022	2,502		20	125	125	500	52
53	Paint 1st Floor & Basement	2022	15,419		20	771	771	3,084	53
54	Installed 3 New Faucets & Basket Strainer	2023	10,500		15	700	700	2,100	54
55	Replace Hoses & Thermostat on Generator	2024	3,015		15	201	201	402	55
56	Install 8 Build in Wardrobe Units,16 Cubicle Tracks & Curtains	2024	25,429		15	1,696	1,696	3,392	56
57	Renovate Shower Rooms	2024	25,126		15	1,675	1,675	3,350	57
58	Repair Shower Room Exhaust	2025	3,589		15	239	239	239	58
59	Install New shower Mixing Valve	2025	4,150		15	277	277	277	59
60	Install Piping from Basement Water Heater to 2 Wash Machines	2025	2,800		15	187	187	187	60
61	Replace Selector Heads, Seth Magnets and Dumbwaiter	2025	6,177		15	412	412	412	61
62	Replace Electrical Panel With New Switches	2025	8,100		15	540	540	540	62
63	Repair Circulating Pump in A Wing	2025	5,375		15	358	358	358	63
64									64
65									65
66									66
67									67
68	Financial Statement Depreciation			44,896			(44,896)		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 590,468	\$ 44,896		\$ 31,238	\$ (13,658)	\$ 154,755	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$24,207	\$	\$2,421	\$2,421	10	\$15,493	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$24,207	\$	\$2,421	\$2,421		\$15,493	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)	\$614,675	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$44,896	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$33,659	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(11,237)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$170,248	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:2320 S Lawndale LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:				\$540,000			3
4	Additions							4
5								5
6	Allocated Jade				2,525			6
7	TOTAL				\$542,525			7

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

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

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

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

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

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

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	\$		\$ 87,475	\$		\$ 87,475	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			33,529			33,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			104,328			104,328	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				44,719		44,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					18,415		18,415	12
13	Other (specify):									13
14	TOTAL			\$		\$ 225,332	\$ 63,134		\$ 288,466	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.

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	\$162,648	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,482,618		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	312,892		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	178,354		8
9	Other(specify): Security Deposit	195,420		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$2,331,932	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	452,713		15
16	Equipment, at Historical Cost	110,681		16
17	Accumulated Depreciation (book methods)	(219,057)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$344,337	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$2,676,269	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$1,390,496	\$	26
27	Officer's Accounts Payable	180,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,157		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,389		31
32	Accrued Real Estate Taxes(Sch.IX-B)	343,298		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)	\$2,073,340	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$2,073,340	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$603,429	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$2,676,769	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 634,180	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 634,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,751)	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)	\$ (30,751)	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)	\$ 603,429	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Little Village Nrsg Rhb Ctr

0054643

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	\$ 10,625,072	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,625,072	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	Misc	173,160	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 173,160	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,798,232	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,741,809	31
32	Health Care	3,705,620	32
33	General Administration	2,761,003	33
	B. Capital Expense		
34	Ownership	1,613,919	34
	C. Ancillary Expense		
35	Special Cost Centers	288,466	35
36	Provider Participation Fee	718,166	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,828,983	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,751)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,751)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 479,648.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,830,180.00	45
46	MMAI-Medicaid is the Primary Payer	319,301.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	228,153.00	48
49	Medicare Part A	1,453,633.00	49
50	Other-(specify) Medicare-B	125,357.00	50
51	Other-(specify)		51
52	Other-(specify) Insurance	188,800.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,625,072	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	1,944	2,088	\$ 117,242	\$ 56.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,400	3,772	172,732	45.79	3
4	Licensed Practical Nurses	21,043	22,704	1,006,735	44.34	4
5	CNAs & Orderlies	52,853	58,479	1,538,662	26.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,946	2,090	50,960	24.38	9
10	Activity Assistants	4,924	5,536	117,639	21.25	10
11	Social Service Workers	4,473	4,791	138,144	28.83	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,094	63,846	30.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,305	18,381	412,808	22.46	15
16	Dishwashers					16
17	Maintenance Workers	1,925	2,205	60,430	27.41	17
18	Housekeepers	19,778	21,578	447,950	20.76	18
19	Laundry	3,853	4,464	100,203	22.45	19
20	Administrator	2,024	2,100	125,905	59.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,103	24,576	540,454	21.99	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	1,933	2,161	56,902	26.33	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,064	2,220	109,759	49.44	33
34	TOTAL (lines 1 - 33)	162,464	179,239	\$ 5,060,371 *	\$ 28.23	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	\$ 6,481	1-3	35
36	Medical Director	Monthly	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	219,528	10-3	38
39	Pharmacist Consultant	Monthly	7,782	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)		\$ 257,791		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	72	\$ 4,340	10-3	50
51	Licensed Practical Nurses	56	3,104	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	128	\$ 7,444		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	%	Amount	Description	Amount	Description	Amount	
Stephani White	Administrator	0	\$ 125,905	Workers' Compensation Insurance	\$ 52,493	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	37,965	Advertising: Employee Recruitment	16,328	
				FICA Taxes	387,473	Health Care Worker Background Check	3,117	
				Employee Health Insurance	246,247	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	1,172	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	18,444	
						Netsmart	3,828	
						Various	1,574	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 125,905					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			PAC and Lobbying payments	(6,148)	
Jade Financial-Mgmt Fees			\$ 512,751			All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 512,751	TOTAL (agree to Schedule V, line 22, col.8)		\$ 724,178	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,305
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Mendel Schneider CPA	Accounting		\$ 10,400					
Neil Gerber	Legal		9,586					
Sher LLP	Legal		4,651					
Elizabeth Nash	Reimb Cons		28,800				In-State Travel	
Guided Care	Case Mgmt		19,800					
Legat	Architect		2,415					
Goodnicki LLP	Legal		6,067					
Stout	Appraisal		5,507				Seminar Expense	
IWC Innovations	Legionella		1,000				Various	1,606
Personnel Planners	UC tax Consultant		2,958					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 91,184				TOTAL	\$ 1,606

*** 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)	12,296
	12,296 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)	6,148
	6,148 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	18,444
	18,444 Total
- (5)

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

\$	29,224	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.

\$	718,166
----	---------

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?

No

Firm Name:
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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