

		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: 0057000

Facility Name: LOFT REHAB OF DECATUR

Address: 500 W MCKINLEY AVE DECATUR 62526
Number City Zip Code

County: MACON

Telephone Number: (217)875-0020 Fax #: (217)875-0647

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2021

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

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)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Judd Schneider CPA

(Firm Name & Address) Mendel Schneider CPA & Associates 4051 Old Orchard Rd, Skokie, IL 60076

(Telephone) (847)933-1274 Fax #: (847)933-1283

In the event there are further questions about this report, please contact:
Name: Judd Schneider Telephone Number: (847)933-1274
Email Address:

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 LOFT REHAB OF DECATUR # 0057000 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	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	6,359	15,358			5,614	3,966	2,151	33,448	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,359	15,358			5,614	3,966	2,151	33,448	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 61.09%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2021

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/2021 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 150

Medicare Intermediary WPS

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		LOFT REHAB OF DECATUR				# 0057000		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	362,575	26,917	19,763	409,255		409,255		409,255			1	
2	Food Purchase		283,942		283,942		283,942		283,942			2	
3	Housekeeping	229,066	30,101	17,910	277,077		277,077		277,077			3	
4	Laundry	91,198	17,353		108,551		108,551		108,551			4	
5	Heat and Other Utilities			167,134	167,134		167,134		167,134			5	
6	Maintenance	80,843	4,887	65,116	150,846		150,846		150,846			6	
7	Other (specify):* Patient Transportation			17,755	17,755		17,755		17,755			7	
8	TOTAL General Services	763,682	363,200	287,678	1,414,560		1,414,560		1,414,560			8	
	B. Health Care and Programs												
9	Medical Director			18,000	18,000		18,000		18,000			9	
10	Nursing and Medical Records	3,475,632	174,365	281,037	3,931,034		3,931,034		3,931,034			10	
10a	Therapy											10a	
11	Activities	70,800	7,321	2,251	80,372		80,372		80,372			11	
12	Social Services	67,322		2,475	69,797		69,797		69,797			12	
13	CNA Training											13	
14	Program Transportation											14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	3,613,754	181,686	303,763	4,099,203		4,099,203		4,099,203			16	
	C. General Administration												
17	Administrative	117,913		633,129	751,042		751,042	(498,014)	253,028			17	
18	Directors Fees											18	
19	Professional Services			119,317	119,317		119,317		119,317			19	
20	Dues, Fees, Subscriptions & Promotions			51,998	51,998		51,998	(19,893)	32,105			20	
21	Clerical & General Office Expenses	285,211	43,103	598,127	926,441		926,441	185,819	1,112,260			21	
22	Employee Benefits & Payroll Taxes			624,925	624,925		624,925		624,925			22	
23	Inservice Training & Education											23	
24	Travel and Seminar			2,714	2,714		2,714		2,714			24	
25	Other Admin. Staff Transportation											25	
26	Insurance-Prop.Liab.Malpractice			254,000	254,000		254,000	287	254,287			26	
27	Other (specify):* Allocated Benifets							80,852	80,852			27	
28	TOTAL General Administration	403,124	43,103	2,284,210	2,730,437		2,730,437	(250,949)	2,479,488			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,780,560	587,989	2,875,651	8,244,200		8,244,200	(250,949)	7,993,251			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			300	300		300	8,877	9,177			30
31	Amortization of Pre-Op. & Org.			18,993	18,993		18,993		18,993			31
32	Interest			81,619	81,619		81,619	(354)	81,265			32
33	Real Estate Taxes			117,042	117,042		117,042		117,042			33
34	Rent-Facility & Grounds			860,691	860,691		860,691	7,865	868,556			34
35	Rent-Equipment & Vehicles							9,235	9,235			35
36	Other (specify):*											36
37	TOTAL Ownership			1,078,645	1,078,645		1,078,645	25,623	1,104,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,988	931,234	1,114,222		1,114,222		1,114,222			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			526,065	526,065		526,065		526,065			42
43	Other (specify):* Bad Debt			180,000	180,000		180,000	(180,000)				43
44	TOTAL Special Cost Centers		182,988	1,637,299	1,820,287		1,820,287	(180,000)	1,640,287			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,780,560	770,977	5,591,595	11,143,132		11,143,132	(405,326)	10,737,806			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	8,877	30		9
10	Interest and Other Investment Income	(354)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(132,932)	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	(180,000)	43		24
25	Fund Raising, Advertising and Promotional	(11,202)	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)	\$ (315,611)		\$	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)	(81,024)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,024)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (396,635)		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

ID#0057000

Report Period Beginning:01/01/2025

Ending:12/31/2025

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (8,691)	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
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,691)		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	Admin Comp-D Aaron	\$	Loft Healthcare Consultants		\$ 43,407	\$ 43,407	15
16	V	17	Admin Comp- R Aaron		Loft Healthcare Consultants		43,549	43,549	16
17	V	17	Admin Comp - A Aaron		Loft Healthcare Consultants		29,122	29,122	17
18	V	17	Admin Comp- C Row		Loft Healthcare Consultants		19,037	19,037	18
19	V	21	Clerical Comp A Aaron		Loft Healthcare Consultants		16,471	16,471	19
20	V	21	Clerical Comp F Aaron		Loft Healthcare Consultants		5,765	5,765	20
21	V								21
22	V	21	Clerical		Loft Healthcare Consultants		267,717	267,717	22
23	V	35	Auto		Loft Healthcare Consultants		9,235	9,235	23
24	V	21	Bank Fees		Loft Healthcare Consultants		786	786	24
25	V	27	Health Insurance		Loft Healthcare Consultants		30,592	30,592	25
26	V	27	Pr Taxes		Loft Healthcare Consultants		50,260	50,260	26
27	V	21	Office		Loft Healthcare Consultants		26,451	26,451	27
28	V	26	Insurance		Loft Healthcare Consultants		287	287	28
29	V	34	Rent		Loft Healthcare Consultants		7,865	7,865	29
30	V	21	Telephone		Loft Healthcare Consultants		1,561	1,561	30
31	V								31
32	V	17	Management Fees	633,129	Loft Healthcare Consultants			(633,129)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 633,129			\$ 552,105	\$ * (81,024)	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	The Loft Rehabilitation & Nursing of Eureka	Eureka,IL			Loft Healthcare Consu	Lincolnwood, IL	Mgmt	1
2	The Loft Rehabilitation & Nursing of Normal	Normal,IL			Misty Meadows Estate	Metropolis,IL	Senior Apts	2
3	The Loft Rehabilitation & Nursing of Canton	Canton, IL						3
4	The Loft Rehabilitation & Nursing of Rock Spri	Rock Springs, IL						4
5	The Loft Rehabilitation & Nursing of Peoria	Peoria, IL						5
6	The Loft Rehabilitation & Nursing of East Peori	East Peoria, IL						6
7								7
8								8
9								9
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel Aaron	Member	Administrative	24.25	260,439	8	14.00	Alloc Wages	\$ 43,407	17-7	1
2	Rober Aaron	Member	Administrative	24.25	261,297	8	14.00	Alloc Wages	43,549	17-7	2
3	Adam Aaron	Member	Administrative	24.25	174,735	8	14.00	Alloc Wages	29,122	17-7	3
4	Cory Row	Member	Administrative	2.00	114,222	8	14.00	Alloc Wages	19,037	17-7	4
5	Adina Aaron	Relative	Clerical	24.25	98,916	5	15.00	Alloc Wages	16,471	21-7	5
6	Fred Aaron	Relative	Clerical		34,622	5	15.00	Alloc Wages	5,765	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 157,351		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 LOFT REHAB OF DECATUR # 0057000 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 Loft Healthcare Consultants
Street Address 8180 Mccormick Blvd #160F
City / State / Zip Code Skokie, IL 60076
Phone Number (847)792-9293
Fax Number (847)603-4939

	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	17	Admin Comp-D Aaron	Hours Allocation	56	7	\$ 303,846	\$ 303,846	8	\$ 43,407	1
2	17	Admin Comp- R Aaron	Hours Allocation	56	7	304,846	304,846	8	43,549	2
3	17	Admin Comp - A Aaron	Hours Allocation	56	7	203,857	203,857	8	29,122	3
4	17	Admin Comp- C Row	Hours Allocation	56	7	133,259	133,259	8	19,037	4
5	21	Clerical Comp A Aaron	Hours Allocation	40	7	115,387	115,387	6	16,471	5
6	21	Clerical Comp F Aaron	Hours Allocation	40	7	40,387	40,387	6	5,765	6
7										7
8	21	Clerical	Number of beds	895	7	1,597,377	1,597,377	150	267,717	8
9	35	Auto	Number of beds	895	7	55,102		150	9,235	9
10	21	Bank Fees	Number of beds	895	7	4,687		150	786	10
11	27	Health Insurance	Number of beds	895	7	182,531		150	30,592	11
12	27	Pr Taxes	Number of beds	895	7	299,885		150	50,260	12
13	21	Office	Number of beds	895	7	157,826		150	26,451	13
14	26	Insurance	Number of beds	895	7	1,713		150	287	14
15	34	Rent	Number of beds	895	7	46,930		150	7,865	15
16	21	Telephone	Number of beds	895	7	9,316		150	1,561	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,456,949	\$ 2,698,959		\$ 552,105	25

Facility Name & ID Number LOFT REHAB OF DECATUR # 0057000 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	CNH Finance LP		X	Working Capital		11/01/2021	740,000					81,619	6
7													7
8													8
9	TOTAL Facility Related						\$ 740,000	\$				\$ 81,619	9
	B. Non-Facility Related*												
10	Interest income											(354)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$ (354)	14
15	TOTALS (line 9+line14)						\$ 740,000	\$				\$ 81,265	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)				\$	116,1672
3. Under or (over) accrual (line 2 minus line 1).				\$	116,1673
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.)				\$	8755
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$	6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	117,0427
Assessed Value from Real Estate Tax Bill:	2024	1,200,000	8		
Real Estate Tax Bill for Calendar Year:	2020	128,924	9		
	2021	126,250	10		
	2022	134,369	11		
	2023	119,430	12		
	2024	116,167	13		
				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.

FACILITY NAME	LOFT REHAB OF DECATUR	COUNTY	MACON
---------------	-----------------------	--------	-------

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior Brick Frame Wood 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).
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.
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: 57,355 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 18,993 4. Dates Incurred: 11/01/2021

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	Replace dry pendantts for sprinkler system on the outside of building			2022	4,645		39	119	119	476
10	saw & jackhammer section of shower floor in the 2nd shower room			2022	3,800		39	97	97	388
11	sprinkler repair			2024	21,699		39	556	556	1,112
12	new heat & a/c			2024	35,800		39	918	918	1,836
13	circuit breaker box panel			2024	4,629		39	119	119	238
14	Door, shutters, and door closers			2024	14,432		39	370	370	740
15	Install new evaporator, condenser in hvac stsystem			2025	38,392		15	2,559	2,559	2,559
16	Capitilized Sprinkler repair			2025	3,003		15	200	200	200
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28	Financial Statement depreciation					300			(300)	
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$126,400	\$300		\$4,939	\$4,639	\$7,549	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	\$ 19,699	\$	\$ 1,970	\$ 1,970	10	\$ 2,955	71
72	Current Year Purchases	22,683		2,268	2,268	10	2,268	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 42,382	\$	\$ 4,238	\$ 4,238		\$ 5,223	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)	\$ 168,782	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,177	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,877	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,772	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:Generations Healthcare of Mckinley LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		150	07/01/2021	\$ 860,691	10		3
4	Additions							4
5	Alloc from mgmt co				7,865			5
6								6
7	TOTAL		150		\$ 868,556			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: \$ 85,055Description: Medcial Equipment Rental
- (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	Alloc from mgmt co		\$	9,235	17
18					18
19					19
20					20
21	TOTAL		\$	9,235	21

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$ 876,000
13.	/2027	\$ 902,280
14.	/2028	\$ 929,348

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 451,938	\$		\$ 451,938	1
2	Licensed Speech and Language Development Therapist		hrs			27,809			27,809	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			451,487			451,487	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				155,998		155,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					26,990		26,990	12
13	Other (specify):									13
14	TOTAL			\$		\$ 931,234	\$ 182,988		\$ 1,114,222	14

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 260,108	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,006,261		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,314,360	\$	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	126,399		15
16	Equipment, at Historical Cost	42,382		16
17	Accumulated Depreciation (book methods)	(1,048)		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>Option Deposit</u>	318,750		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 486,483	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,800,843	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,740,685	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,649		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,850		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	<u>due to related</u>	1,050,822		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,006,006	\$	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)	\$ 3,006,006	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (205,163)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,800,843	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (190,258)	1
2	Restatements (describe):		2
3	Prior Period adj	26,514	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (163,744)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,195	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	(125,614)	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)	\$ (41,419)	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)	\$ (205,163)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LOFT REHAB OF DECATUR

0057000

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	\$ 11,226,973	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,226,973	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***	354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 354	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,227,327	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,414,560	31
32	Health Care	4,099,203	32
33	General Administration	2,730,437	33
	B. Capital Expense		
34	Ownership	1,078,645	34
	C. Ancillary Expense		
35	Special Cost Centers	1,294,222	35
36	Provider Participation Fee	526,065	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,143,132	40
41	Income before Income Taxes (line 30 minus line 40)**	84,195	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 84,195	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,675,837.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,017,802.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,425,239.00	48
49	Medicare Part A	2,573,649.00	49
50	Other-(specify) Insurance	892,037.00	50
51	Other-(specify) Med B	642,409.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,226,973	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	1,243	1,290	\$ 76,924	\$ 59.63	1
2	Assistant Director of Nursing	2,602	2,850	135,054	47.39	2
3	Registered Nurses	7,818	8,435	400,202	47.45	3
4	Licensed Practical Nurses	26,655	28,284	1,147,015	40.55	4
5	CNAs & Orderlies	72,641	76,422	1,680,977	22.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	692	771	16,218	21.04	9
10	Activity Assistants	3,531	3,568	54,582	15.30	10
11	Social Service Workers	2,219	2,453	67,322	27.44	11
12	Dietician					12
13	Food Service Supervisor	2,063	2,235	65,993	29.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,884	17,683	296,582	16.77	15
16	Dishwashers					16
17	Maintenance Workers	2,946	3,220	80,843	25.11	17
18	Housekeepers	11,819	13,064	229,066	17.53	18
19	Laundry	5,131	5,767	91,198	15.81	19
20	Administrator	1,800	1,918	117,913	61.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,470	12,186	285,211	23.40	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	1,709	1,812	35,460	19.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,223	181,958	\$ 4,780,560 *	\$ 26.27	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	\$ 19,763	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	Monthly	2,568	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,634	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	Monthly	2,251	11-3	44
45	Social Service Consultant	Monthly	2,475	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,691		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	699	\$ 41,914	10-3	50
51	Licensed Practical Nurses	1,214	66,758	10-3	51
52	Certified Nurse Assistants/Aides	2,117	74,108	10-3	52
53	TOTAL (lines 50 - 52)	4,030	\$ 182,780		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Louise Mikle	Administrative		\$ 48,697	Workers' Compensation Insurance		\$ 54,255	IDPH License Fee	\$	
Kerri Row	Administrative		21,603	Unemployment Compensation Insurance		81,045	Advertising: Employee Recruitment	10,084	
Janice Tabor	Administrative		31,733	FICA Taxes		374,356	Health Care Worker Background Check		
Jill West	Administrative		15,880	Employee Health Insurance		115,269	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	2,645	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	26,100	
							Misc License	1,967	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 117,913						
B. Administrative - Other									
Description			Amount						
Loft Healthcare Mgmt			\$ 633,129						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 633,129						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
KBKB	Accounting		\$ 8,200			\$	Out-of-State Travel	\$	
O'Hagen Meyer	Legal		4,528						
Stone Pogrund & Korey	Legal		2,341						
Ice Miller LLP	Legal		45,297				In-State Travel		
Plante Moran	Accounting		3,714						
MTS Consulting	WOTC		1,537						
Silver Key	Pa Consulting		20,055						
Elite Standard Recruitment	Placement		19,500				Seminar Expense		
Correl Co	Retirement Plan		2,574				Misc Seminar	2,714	
RB Health Partners	Reimbursement consultant		11,571						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()	
(For legal fee disclosure, see page 39 of instructions)			\$ 119,317				(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 2,714	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	17,409
	17,409 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	8,691
	8,691 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	26,100
	26,100 Total
- (5)

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

\$	23,925	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.

\$	526,065
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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.

\$	None	Has any meal income been offset against related costs?	None	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.

\$

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

100

d. Have vehicle usage logs been maintained?

No

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

No

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

No

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.

\$
- (13)

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

Firm Name:

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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