

		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: 0058453 Facility Name: Loft Rehab of East Peoria Address: 900 Centennial Drive East Peoria 61611 County: Tazewell Telephone Number: (309)699-5400 Fax #: (309)699-1632 HFS ID Number: Date of Initial License for Current Owners: 12/01/2023 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: Judd 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) (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 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630
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Facility Name & ID Number Loft Rehab of East Peoria # 0058453 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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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	11,539	12,471			7,497	5,003	4,616	41,126	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	11,539	12,471			7,497	5,003	4,616	41,126	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.89%

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 12/01/2023

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/01/2023 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 120

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Loft Rehab of East Peoria # 0058453 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	448,330	38,180	48,776	535,286		535,286		535,286			1
2	Food Purchase		344,740		344,740		344,740		344,740			2
3	Housekeeping	233,326	29,050	19,597	281,973		281,973		281,973			3
4	Laundry	53,709	13,424		67,133		67,133		67,133			4
5	Heat and Other Utilities			234,531	234,531		234,531		234,531			5
6	Maintenance	51,303	6,273	123,775	181,351		181,351		181,351			6
7	Other (specify):* Patient Transportation			75,368	75,368		75,368		75,368			7
8	TOTAL General Services	786,668	431,667	502,047	1,720,382		1,720,382		1,720,382			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,591,311	261,173	52,775	4,905,259		4,905,259		4,905,259			10
10a	Therapy											10a
11	Activities	83,867	3,152	3,132	90,151		90,151		90,151			11
12	Social Services	61,043		3,048	64,091		64,091		64,091			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,736,221	264,325	76,955	5,077,501		5,077,501		5,077,501			16
	C. General Administration											
17	Administrative	167,367		794,677	962,044		962,044	(659,562)	302,482			17
18	Directors Fees											18
19	Professional Services			36,867	36,867		36,867		36,867			19
20	Dues, Fees, Subscriptions & Promotions			46,822	46,822		46,822	(14,432)	32,390			20
21	Clerical & General Office Expenses	268,130	53,763	439,103	760,996		760,996	251,299	1,012,295			21
22	Employee Benefits & Payroll Taxes			707,000	707,000		707,000		707,000			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			169,000	169,000		169,000	230	169,230			26
27	Other (specify):*							64,681	64,681			27
28	TOTAL General Administration	435,497	53,763	2,196,183	2,685,443		2,685,443	(357,784)	2,327,659			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,958,386	749,755	2,775,185	9,483,326		9,483,326	(357,784)	9,125,542			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							3,153	3,153			30
31	Amortization of Pre-Op. & Org.			8,220	8,220		8,220		8,220			31
32	Interest			85,813	85,813		85,813	(1,149)	84,664			32
33	Real Estate Taxes			92,680	92,680		92,680		92,680			33
34	Rent-Facility & Grounds			860,848	860,848		860,848	6,292	867,140			34
35	Rent-Equipment & Vehicles							7,388	7,388			35
36	Other (specify):*											36
37	TOTAL Ownership			1,047,561	1,047,561		1,047,561	15,684	1,063,245			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		379,165	736,549	1,115,714		1,115,714		1,115,714			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			611,384	611,384		611,384		611,384			42
43	Other (specify):* Bad Debt Expense			120,000	120,000		120,000	(120,000)				43
44	TOTAL Special Cost Centers		379,165	1,467,933	1,847,098		1,847,098	(120,000)	1,727,098			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,958,386	1,128,920	5,290,679	12,377,985		12,377,985	(462,100)	11,915,885			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	3,153	30		9
10	Interest and Other Investment Income	(1,149)	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	(8,148)	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	(120,000)	43		24
25	Fund Raising, Advertising and Promotional	(7,472)	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)	\$ (133,616)		\$	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)	(321,524)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (321,524)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (455,140)		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	\$ (6,960)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
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48				48
49	Total	(6,960)		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		214,173	214,173	22
23	V	35	Auto		Loft Healthcare Consultants		7,388	7,388	23
24	V	21	Bank Fees		Loft Healthcare Consultants		628	628	24
25	V	27	Health Insurance		Loft Healthcare Consultants		24,473	24,473	25
26	V	27	Pr Taxes		Loft Healthcare Consultants		40,208	40,208	26
27	V	21	Office		Loft Healthcare Consultants		21,161	21,161	27
28	V	26	Insurance		Loft Healthcare Consultants		230	230	28
29	V	34	Rent		Loft Healthcare Consultants		6,292	6,292	29
30	V	21	Telephone		Loft Healthcare Consultants		1,249	1,249	30
31	V								31
32	V	17	Management Fees	794,677	Loft Healthcare Consultants			(794,677)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 794,677			\$ 473,153	\$ * (321,524)	39

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

Ownership Listing-1

ID# 0058453

12/31/2025

12/31/2025

sted. (Full legal name)

Management

Operator/Licensee

Ownership

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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 Sprin	Rock Springs, IL						4
5	The Loft Rehabilitation & Nursing of Peoria	Peoria, IL						5
6	The Loft Rehabilitation & Nursing of Decatur	Decatur, IL						6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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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	24.50	260,439	8	14.00	Alloc wages	\$ 43,407	17-7	1
2	Rober Aaron	Member	Administrative	24.50	261,297	8	14.00	Alloc wages	43,549	17-7	2
3	Adam Aaron	Member	Administrative	24.50	174,735	8	14.00	Alloc wages	29,122	17-7	3
4	Cory Row	Member	Administrative		114,222	8	14.00	Alloc wages	19,037	17-7	4
5	Adina Aaron	Relative	Clerical		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 East Peoria # 0058453 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	120	214,173	8
9	35	Auto	Number of beds	895		55,102		120	7,388	9
10	21	Bank Fees	Number of beds	895		4,687		120	628	10
11	27	Health Insurance	Number of beds	895		182,531		120	24,473	11
12	27	Pr Taxes	Number of beds	895		299,885		120	40,208	12
13	21	Office	Number of beds	895		157,826		120	21,161	13
14	26	Insurance	Number of beds	895		1,713		120	230	14
15	34	Rent	Number of beds	895		46,930		120	6,292	15
16	21	Telephone	Number of beds	895		9,316		120	1,249	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		\$ 473,153	25

Ending: 2/31/2025

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CNH FINANCE LP		X	Working Capital								85,813	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 85,813	9
	B. Non-Facility Related*												
10	Interest Income											(1,149)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (1,149)	14
15	TOTALS (line 9+line14)						\$		\$			\$ 84,664	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.)				\$	92,680 2
3. Under or (over) accrual (line 2 minus line 1).				\$	92,680 3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$	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.				\$	92,680 7
Assessed Value from Real Estate Tax Bill:	2024	1,022,920	8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023	89,805	12		
	2024	92,680	13		
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

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

FACILITY NAME Loft Rehab of East Peoria COUNTY Tazewell
FACILITY IDPH LICENSE NUMBER 0058453
CONTACT PERSON REGARDING THIS REPORT Judd Schneider
TELEPHONE (847)933-1274 FAX #: (847)933-1283

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.

B. Real Estate Tax Cost Allocations

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

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

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 provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

39,125

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

☒

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:

56,525

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

5

3. Current Period Amortization:

8,220

4. Dates Incurred:

12/01/2023

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	Lofted garage 12x 24			2025	12,416		15	828	828	828
10	Boiler Replacement			2025	8,314		15	554	554	554
11	Maas Radiator repair			2025	4,914		15	328	328	328
12	Replace air handler			2025	7,314		15	488	488	488
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

*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)		\$ 32,958	\$		\$ 2,197	\$ 2,197	\$ 2,198	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	9,556		956	956	10	1,434	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 9,556	\$	\$ 956	\$ 956		\$ 1,434	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)	\$ 42,514	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,153	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,153	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,632	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:CCG Barbados 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.

YESNO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	12/1/23	\$858,696			3
4	Additions							4
5	Parking Lot Rental				2,152			5
6	Allocated rent				6,292			6
7	TOTAL		120		\$867,140			7

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

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

9. Option to Buy:

YESNO

Terms:

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$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

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

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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	\$		\$ 341,047	\$		\$ 341,047	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			43,535			43,535	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			351,967			351,967	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				281,408		281,408	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					97,757		97,757	12
13	Other (specify):									13
14	TOTAL			\$		\$ 736,549	\$ 379,165		\$ 1,115,714	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	\$123,395	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,775,776		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,345		6
7	Other Prepaid Expenses	1,361		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from others	569,491		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$2,510,368	\$	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	32,957		15
16	Equipment, at Historical Cost	33,792		16
17	Accumulated Depreciation (book methods)	(220)		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): Option Deposit	537,500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$604,029	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$3,114,397	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$634,964	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	251,436		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$886,400	\$	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)	\$886,400	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$2,227,997	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$3,114,397	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 756,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 756,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,598,290	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	(126,541)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,471,749	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)	\$ 2,227,997	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Loft Rehab of East Peoria

0058453

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	\$ 13,975,126	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,975,126	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***	1,149	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,149	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)	\$ 13,976,275	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,720,382	31
32	Health Care	5,077,501	32
33	General Administration	2,685,443	33
	B. Capital Expense		
34	Ownership	1,047,561	34
	C. Ancillary Expense		
35	Special Cost Centers	1,235,714	35
36	Provider Participation Fee	611,384	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,377,985	40
41	Income before Income Taxes (line 30 minus line 40)**	1,598,290	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,598,290	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,048,619.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,241,357.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,956,606.00	48
49	Medicare Part A	3,397,330.00	49
50	Other-(specify) Insurance	1,991,983.00	50
51	Other-(specify) Med b	339,231.00	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)	\$ 13,975,126	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	1,792	2,080	\$ 147,962	\$ 71.14	1
2	Assistant Director of Nursing	3,840	4,085	180,910	44.29	2
3	Registered Nurses	7,129	7,544	367,600	48.73	3
4	Licensed Practical Nurses	39,474	42,875	1,800,405	41.99	4
5	CNAs & Orderlies	93,304	98,609	2,094,434	21.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,926	2,072	46,070	22.23	9
10	Activity Assistants	2,391	2,479	37,797	15.25	10
11	Social Service Workers	1,986	2,179	61,043	28.01	11
12	Dietician					12
13	Food Service Supervisor	2,410	2,588	75,356	29.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,547	23,298	372,974	16.01	15
16	Dishwashers					16
17	Maintenance Workers	1,836	1,928	51,303	26.61	17
18	Housekeepers	12,932	13,544	233,326	17.23	18
19	Laundry	3,324	3,528	53,709	15.22	19
20	Administrator	1,848	2,080	167,367	80.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,110	17,441	268,130	15.37	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,849	226,330	\$ 5,958,386 *	\$ 26.33	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	\$ 48,776	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	Monthly	2,502	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,687	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	3,132	11-3	44
45	Social Service Consultant	Monthly	3,048	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 88,145		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number	Loft Rehab of East Peoria
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0058453

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	13,920
	13,920 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)	6,960
	6,960 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	20,880
	20,880 Total
- (5)

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

\$ 10,863 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.

\$ 611,384

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?

Yes

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. \$ None
- (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.