

		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: <u>0058446</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>The Loft Rehab of Peoria</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>1500 W Northmoor Rd</u> <u>Peoria</u> <u>61614</u>																																																			
Number City Zip Code																																																			
County: <u>Peoria</u>																																																			
Telephone Number: <u>(309)691-2200</u> Fax # <u>(309)691-1548</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>12/01/2023</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Judd Schneider</u>																																																			
Telephone Number: <u>(847)933-1274</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Judd Schneider</u> <u>CPA</u></td></tr><tr><td colspan="2">(Firm Name & Address) <u>Mendel Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u></td></tr><tr><td colspan="2">(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____	(Print Name and Title) <u>Judd Schneider</u> <u>CPA</u>	(Firm Name & Address) <u>Mendel Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u>		(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																																		
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Facility Name & ID Number The Loft Rehab of Peoria # 0058446 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</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>120</u>	TOTALS	<u>120</u>	<u>43,800</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	7,783	19,042			2,271	2,492	2,257	33,845	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,783	19,042			2,271	2,492	2,257	33,845	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 77.27%

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 The Loft Rehab of Peoria # 0058446 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	408,890	25,886	19,729	454,505		454,505		454,505			1
2	Food Purchase		279,856		279,856		279,856		279,856			2
3	Housekeeping	179,981	26,516	25,047	231,544		231,544		231,544			3
4	Laundry	64,120	15,451		79,571		79,571		79,571			4
5	Heat and Other Utilities			206,039	206,039		206,039		206,039			5
6	Maintenance	88,742	14,644	123,298	226,684		226,684		226,684			6
7	Other (specify):* Patient Transportation			35,033	35,033		35,033		35,033			7
8	TOTAL General Services	741,733	362,353	409,146	1,513,232		1,513,232		1,513,232			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,544,081	192,295	114,773	3,851,149		3,851,149		3,851,149			10
10a	Therapy											10a
11	Activities	93,817	2,086	3,042	98,945		98,945		98,945			11
12	Social Services	50,569		3,042	53,611		53,611		53,611			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,688,467	194,381	138,857	4,021,705		4,021,705		4,021,705			16
	C. General Administration											
17	Administrative	141,558		606,699	748,257		748,257	(471,584)	276,673			17
18	Directors Fees											18
19	Professional Services			76,574	76,574		76,574		76,574			19
20	Dues, Fees, Subscriptions & Promotions			47,731	47,731		47,731	(17,697)	30,034			20
21	Clerical & General Office Expenses	325,117	45,975	582,957	954,049		954,049	57,861	1,011,910			21
22	Employee Benefits & Payroll Taxes			594,410	594,410		594,410		594,410			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			163,500	163,500		163,500	230	163,730			26
27	Other (specify):*							64,681	64,681			27
28	TOTAL General Administration	466,675	45,975	2,074,585	2,587,235		2,587,235	(366,509)	2,220,726			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,896,875	602,709	2,622,588	8,122,172		8,122,172	(366,509)	7,755,663			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							14,987	14,987			30
31	Amortization of Pre-Op. & Org.			7,260	7,260		7,260		7,260			31
32	Interest			85,813	85,813		85,813	(525)	85,288			32
33	Real Estate Taxes			95,386	95,386		95,386		95,386			33
34	Rent-Facility & Grounds			857,948	857,948		857,948	6,292	864,240			34
35	Rent-Equipment & Vehicles							7,388	7,388			35
36	Other (specify):*											36
37	TOTAL Ownership			1,046,407	1,046,407		1,046,407	28,142	1,074,549			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,152	599,983	788,135		788,135		788,135			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			526,624	526,624		526,624		526,624			42
43	Other (specify):* Bade debt			120,000	120,000		120,000	(120,000)				43
44	TOTAL Special Cost Centers		188,152	1,246,607	1,434,759		1,434,759	(120,000)	1,314,759			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,896,875	790,861	4,915,602	10,603,338		10,603,338	(458,367)	10,144,971			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	14,987	30		9
10	Interest and Other Investment Income	(525)	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	(201,586)	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	(10,737)	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)	\$ (317,861)		\$	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)	(133,546)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,546)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (451,407)		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	606,699	Loft Healthcare Consultants			(606,699)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 606,699			\$ 473,153	\$ * (133,546)	39

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

Ownership Listing-2

ID# 0058446

01/01/2025

12/31/2025

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 Spri	Rock Springs, IL						4
5	The Loft Rehabilitation & Nursing of East Peori	East Peoria, IL						5
6	The Loft Rehabilitation & Nursing of Decatur	Decatur, IL						6
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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		260,439	8	14.00	Alloc wages	\$ 43,407	17-7	1
2	Rober Aaron	Member	Administrative		261,297	8	14.00	Alloc wages	43,549	17-7	2
3	Adam Aaron	Member	Administrative		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

Ending: 2/31/2025

((847)603-4939

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
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	7	55,102		120	7,388	9
10	21	Bank Fees	Number of beds	895	7	4,687		120	628	10
11	27	Health Insurance	Number of beds	895	7	182,531		120	24,473	11
12	27	Pr Taxes	Number of beds	895	7	299,885		120	40,208	12
13	21	Office	Number of beds	895	7	157,826		120	21,161	13
14	26	Insurance	Number of beds	895	7	1,713		120	230	14
15	34	Rent	Number of beds	895	7	46,930		120	6,292	15
16	21	Telephone	Number of beds	895	7	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	Ecapital Healthcare		X	Working Capital		01/11/24	3,000,000	1,698,862				85,813	6
7													7
8													8
9	TOTAL Facility Related						\$ 3,000,000	\$ 1,698,862			\$ 85,813	9	
	B. Non-Facility Related*												
10	Interest income											(525)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ (525)	14	
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 1,698,862			\$ 85,288	15	

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

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

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

B. Real Estate Taxes

\$

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 The Loft Rehab of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0058446

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.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-326-009</u>	<u>Skilled Nursing Facility</u>	\$ <u>92,459.84</u>	\$ <u>92,459.84</u>
2. <u>14-17-326-010</u>	<u>Skilled Nursing Facility</u>	\$ <u>1,904.92</u>	\$ <u>1,904.92</u>
3. <u>14-17-376-001</u>	<u>Skilled Nursing Facility</u>	\$ <u>1,021.20</u>	\$ <u>1,021.20</u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
	TOTALS	\$ <u>95,385.96</u>	\$ <u>95,385.96</u>

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

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

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: 38,500 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: 7,260 4. Dates Incurred: 01/11/2024

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	Light Hea & Ploe repair			2024	4,685		20	234	234	468
10	Replacement of metal valleys, shingles, and roofing sheets			2025	13,245		15	883	883	883
11	Removal of old carpet & install new flooring in reception area			2025	7,964		15	531	531	531
12	Install 2 new BI Accelerators			2025	5,593		15	373	373	373
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$ 31,487	\$		\$ 2,021	\$ 2,021	\$ 2,255	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	\$99,965	\$	\$9,997	\$9,997		\$13,196	71
72	Current Year Purchases	29,696		2,969	2,969		2,969	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$129,661	\$	\$12,966	\$12,966		\$16,165	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	2	
	Reference	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)	\$161,148	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)	\$14,987	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$14,987	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$18,420	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. 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:		120	12/01/23	\$ 857,948			3
4	Additions							4
5	Alloc from mgmt				6,292			5
6								6
7	TOTAL		120		\$ 864,240			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc from mgmt co		\$	\$ 7,388	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,388	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	\$		\$ 300,904	\$		\$ 300,904	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,733			19,733	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			279,346			279,346	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				147,828		147,828	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					40,324		40,324	12
13	Other (specify):									13
14	TOTAL			\$		\$ 599,983	\$ 188,152		\$ 788,135	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	\$ (198,256)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,106,085		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,637		6
7	Other Prepaid Expenses	1,790		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related	410,262		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,394,518	\$	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	31,487		15
16	Equipment, at Historical Cost	129,660		16
17	Accumulated Depreciation (book methods)	(870)		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)	\$ 697,777	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,092,295	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 250,647	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,698,862		29
30	Accrued Salaries Payable	175,611		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,124		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)	\$ 2,145,244	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,145,244	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (52,949)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,092,295	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (208,137)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (208,137)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,188	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 155,188	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)	\$ (52,949)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Loft Rehab of Peoria

0058446

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,758,001	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,758,001	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***	525	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 525	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)	\$ 10,758,526	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,513,232	31
32	Health Care	4,021,705	32
33	General Administration	2,587,235	33
	B. Capital Expense		
34	Ownership	1,046,407	34
	C. Ancillary Expense		
35	Special Cost Centers	908,135	35
36	Provider Participation Fee	526,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,603,338	40
41	Income before Income Taxes (line 30 minus line 40)**	155,188	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 155,188	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,002,303.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,900,660.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	598,787.00	48
49	Medicare Part A	1,607,940.00	49
50	Other-(specify) Insurance	1,118,027.00	50
51	Other-(specify) Med B	530,284.00	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)	\$ 10,758,001	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	1,560	1,689	\$ 96,867	\$ 57.35	1
2	Assistant Director of Nursing	3,096	3,214	162,003	50.41	2
3	Registered Nurses	7,943	8,224	406,356	49.41	3
4	Licensed Practical Nurses	28,276	30,301	1,295,263	42.75	4
5	CNAs & Orderlies	70,790	73,449	1,534,663	20.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,865	2,023	39,944	19.74	9
10	Activity Assistants	3,307	3,630	53,872	14.84	10
11	Social Service Workers	1,894	2,042	50,569	24.76	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	52,965	25.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,769	20,852	355,925	17.07	15
16	Dishwashers					16
17	Maintenance Workers	3,613	3,879	88,742	22.88	17
18	Housekeepers	10,435	11,062	179,981	16.27	18
19	Laundry	3,782	4,160	64,120	15.41	19
20	Administrator	2,024	2,080	141,558	68.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	12,158	13,995	325,117	23.23	23
24	Clerical					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	2,067	2,151	48,930	22.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,563	184,831	\$ 4,896,875 *	\$ 26.49	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	\$ 19,729	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	Monthly	2,609	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,030	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	3,042	11-3	44
45	Social Service Consultant	Monthly	3,042	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 57,452		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	81	\$ 4,851	10-3	50
51	Licensed Practical Nurses	549	30,186	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	630	\$ 35,037		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberThe Loft Rehab of Peoria# 0058446Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Pollard	Administrative		\$ 141,558
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 141,558

B. Administrative - Other

Description	Amount
Loft Healthcare Consultants	\$ 606,699
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KBKB	Accounting	\$ 10,199
Plante Moran	Accounting	3,715
Stone Pogrund & Korey	Legal	4,449
Jackson Lewis PC	Legal	5,602
Ice Miller LP	Legal	31,043
MTS Consulting	WOTC	3,457
LeaderStat	Placement	13,000
Personal Planners	SUC Consultant	2,225
Correl Co	Retirement Consulting	2,574
RB health consulting	Healthcare consulting	310
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 70,214
Unemployment Compensation Insurance	53,874
FICA Taxes	391,249
Employee Health Insurance	79,073
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	10,084
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	3,139
Association Dues (total from pg 22, #4)	20,880
Misc License	901
Less: Public Relations Expense	()
PAC and Lobbying payments	(6,960)
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Misc Seminar	2,714
Entertainment Expense	()
(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?

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.

\$ 8,678

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.

\$ 526,624

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.

\$ 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.