FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0056994

Facility Name: LOFT REHAB OF ROCK SPRINGS

Address: 2530 NORTH MONROE ST (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (217)875-0920 **Fax #** (217)875-9351

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,175	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	195	TOTALS	195	71,175	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF	8,519	25,308			2,103	1,245	1,017	38,192	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	8,519	25,308			2,103	1,245	1,017	38,192	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 53.66%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 195

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 ROCK SPRINGS # 0056994 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	340,280	53,084	21,311	414,675		414,675		414,675			1
2	Food Purchase		308,106		308,106		308,106		308,106			2
3	Housekeeping	177,471	42,269	17,046	236,786		236,786		236,786			3
4	Laundry	68,081	24,779		92,860		92,860		92,860			4
5	Heat and Other Utilities			214,159	214,159		214,159		214,159			5
6	Maintenance	73,728	8,410	108,146	190,284		190,284		190,284			6
7	Other (specify):* Patient Transportation			300	300		300		300			7
8	TOTAL General Services	659,560	436,648	360,962	1,457,170		1,457,170		1,457,170			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,661,539	138,449	52,707	3,852,695		3,852,695		3,852,695			10
10a	Therapy											10a
11	Activities	133,955	8,103	2,250	144,308		144,308		144,308			11
12	Social Services	54,154		2,250	56,404		56,404		56,404			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,849,648	146,552	75,207	4,071,407		4,071,407		4,071,407			16
	C. General Administration											
17	Administrative	127,271		495,005	622,276		622,276	(359,890)	262,386			17
18	Directors Fees											18
19	Professional Services			45,725	45,725		45,725		45,725			19
20	Dues, Fees, Subscriptions & Promotions			58,910	58,910		58,910	(22,193)	36,717			20
21	Clerical & General Office Expenses	324,645	38,710	445,049	808,404		808,404	367,217	1,175,621			21
22	Employee Benefits & Payroll Taxes			679,858	679,858		679,858		679,858			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,962	5,962		5,962		5,962			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			314,000	314,000		314,000	373	314,373			26
27	Other (specify):* Allocated benifets							105,107	105,107			27
28	TOTAL General Administration	451,916	38,710	2,044,509	2,535,135		2,535,135	90,614	2,625,749			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,961,124	621,910	2,480,678	8,063,712		8,063,712	90,614	8,154,326			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.

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS #0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			216	216		216	9,575	9,791			30
31	Amortization of Pre-Op. & Org.			20,481	20,481		20,481		20,481			31
32	Interest			103,803	103,803		103,803	(464)	103,339			32
33	Real Estate Taxes			141,981	141,981		141,981		141,981			33
34	Rent-Facility & Grounds			1,085,042	1,085,042		1,085,042	10,225	1,095,267			34
35	Rent-Equipment & Vehicles							12,005	12,005			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,351,523	1,351,523		1,351,523	31,341	1,382,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,603	580,101	703,704		703,704		703,704			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			740,275	740,275		740,275		740,275			42
43	Other (specify):* **Bad debt expense**			120,000	120,000		120,000	(120,000)				43
44	**TOTAL Special Cost Centers**		123,603	1,440,376	1,563,979		1,563,979	(120,000)	1,443,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,961,124	745,513	5,272,577	10,979,214		10,979,214	1,955	10,981,169			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	9,575	30		9
10	Interest and Other Investment Income	(464)	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	(40,489)	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	(10,648)	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)**	$ (162,026)		$	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)	175,526		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 175,526		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,500		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

LOFT REHAB OF ROCK SPRINGS

ID# 0056994

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (11,545)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,545)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(359,890)	0	0	0	0	0	0	0	0	(359,890)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,193)	0	0	0	0	0	0	0	0	0	0	(22,193)	20
21	Clerical & General Office Expenses	(40,489)	0	407,706	0	0	0	0	0	0	0	0	367,217	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	373	0	0	0	0	0	0	0	0	373	26
27	Other (specify):*	0	0	105,107	0	0	0	0	0	0	0	0	105,107	27
28	**TOTAL General Administration**	(62,682)	0	153,296	0	0	0	0	0	0	0	0	90,614	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(62,682)	0	153,296	0	0	0	0	0	0	0	0	90,614	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 **Report Period Beginning:** 01/01/2025 **Ending:** 12/31/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,575	0	0	0	0	0	0	0	0	0	0	9,575	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(464)	0	0	0	0	0	0	0	0	0	0	(464)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	10,225	0	0	0	0	0	0	0	0	10,225	34
35	Rent-Equipment & Vehicles	0	0	12,005	0	0	0	0	0	0	0	0	12,005	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,111	0	22,230	0	0	0	0	0	0	0	0	31,341	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	43
44	**TOTAL Special Cost Centers**	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(173,571)	0	175,526	0	0	0	0	0	0	0	0	1,955	45

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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		348,032	348,032	22
23	V	35	Auto		Loft Healthcare Consultants		12,005	12,005	23
24	V	21	Bank Fees		Loft Healthcare Consultants		1,021	1,021	24
25	V	27	Health Insurance		Loft Healthcare Consultants		39,769	39,769	25
26	V	27	Pr Taxes		Loft Healthcare Consultants		65,338	65,338	26
27	V	21	Office		Loft Healthcare Consultants		34,387	34,387	27
28	V	26	Insurance		Loft Healthcare Consultants		373	373	28
29	V	34	Rent		Loft Healthcare Consultants		10,225	10,225	29
30	V	21	Telephone		Loft Healthcare Consultants		2,030	2,030	30
31	V								31
32	V	17	Management Fees	495,005	Loft Healthcare Consultants			(495,005)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 495,005			$ 670,531	$ * 175,526	39

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

STATE OF ILLINOIS — **Ownership Listing-1**

LOFT REHAB OF ROCK SPRINGS

ID# 0056994

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Daniel		Aaron			24.25000		25.00000	1
2	Robert	J	Aaron			24.25000		25.00000	2
3	Adam	T	Aaron			24.25000		25.00000	3
4	Michael	B	Aaron			24.25000		25.00000	4
5	Mordechai	S	Eisenbach	Cleveland	OH	1.00000			5
6	Cory	J	Row	Lewiston	Il	2.00000			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
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62									62
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67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

LOFT REHAB OF ROCK SPRINGS

ID# **0056994**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
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140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 East peori	East Peoria, 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
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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel Aaron	Member	Administrative	24.25	260,439	8	14.00	Alloc wages	$ 43,407	17-7	1
2	Rober Aaron	Member	Administrative	24.25	261,297	8	14.00	Alloc wages	43,549	17-7	2
3	Adam Aaron	Member	Administrative	24.25	174,735	8	14.00	Alloc wages	29,122	17-7	3
4	Cory Row	Member	Administrative	2.00	114,222	8	14.00	Alloc wages	19,037	17-7	4
5	Adina Aaron	Relative	Clerical		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 ROCK SPRINGS # 0056994 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 [X] 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 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	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	195	348,032	8
9	35	Auto	Number of beds	895	7	55,102		195	12,005	9
10	21	Bank Fees	Number of beds	895	7	4,687		195	1,021	10
11	27	Health Insurance	Number of beds	895	7	182,531		195	39,769	11
12	27	Pr Taxes	Number of beds	895	7	299,885		195	65,338	12
13	21	Office	Number of beds	895	7	157,826		195	34,387	13
14	26	Insurance	Number of beds	895	7	1,713		195	373	14
15	34	Rent	Number of beds	895	7	46,930		195	10,225	15
16	21	Telephone	Number of beds	895	7	9,316		195	2,030	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		$ 670,531	25

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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							1,801,816			103,803	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,801,816			$ 103,803	9
	B. Non-Facility Related*											
10	Interest income										(464)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (464)	14
15	TOTALS (line 9+line14)						$	$ 1,801,816			$ 103,339	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.)

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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.)	$	141,981	2
3. Under or (over) accrual (line 2 minus line 1).	$	141,981	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. **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.	$	141,981	7

Assessed Value from Real Estate Tax Bill:	2024	1,466,666	8
Real Estate Tax Bill for Calendar Year:	2020	163,148	9
	2021	159,764	10
	2022	170,039	11
	2023	145,970	12
	2024	141,981	13

FOR BHF USE ONLY

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

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LOFT REHAB OF ROCK SPRINGS COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0056994

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-014	Long Term Care Facility	$ 141,981.48	$ 141,981.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 141,981.48	$ 141,981.48

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Numb LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 64,795
2. Number of Years Over Which it is Being Amortized: 3
3. Current Period Amortization: 20,481
4. Dates Incurred: 10/31/24

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install New Compressor & Filter Drier, Pressure tested, vaccumed system										9
10	Recharged, and checked wiring in hall & kitchen			2022	5,942		39	152	152	608	10
11	Paint walls in facility			2024	5,013		39	129	129	516	11
12	4th floor shower base replacement			2024	5,773		39	148	148	296	12
13	Cable, sounder,keypad installation			2024	13,367		39	343	343	686	13
14	replace pump & motor			2024	2,649		39	68	68	136	14
15	Fire alarm panel CPU upgrade of 4100U to 4100ES			2025	38,254		15	2,550	2,550	2,550	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27	financial statement depreciation					216			(216)		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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 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
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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)		$ 70,998	$ 216		$ 3,390	$ 3,174	$ 4,792	70

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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 32,737	$	$ 3,274	$ 3,274		$ 4,939	71
72	Current Year Purchases	31,268		3,127	3,127		3,127	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 64,005	$	$ 6,401	$ 6,401		$ 8,066	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)	$ 135,003	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,791	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,575	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,858	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.

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Prairie Creek Landlord

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. [X] 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:		195	07/01/2021	$ 1,085,042			3
4	Additions							4
5	Allocated from mgmt co				10,225			5
6								6
7	TOTAL		195		$ 1,095,267 **			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: *

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	$ 1,138,800
13.	/2027	$ 1,172,964
14.	/2028	$ 1,208,153

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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	Mgmt co allocation		$	$ 12,005	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,005	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.

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 320,144	$		$ 320,144	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			24,576			24,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			235,381			235,381	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				99,447		99,447	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					24,156		24,156	12
13	Other (specify):									13
14	TOTAL			$		$ 580,101	$ 123,603		$ 703,704	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.

STATE OF ILLINOIS

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (196,003)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,651,946		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,326		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,467,269	$	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	70,998		15
16	Equipment, at Historical Cost	64,005		16
17	Accumulated Depreciation (book methods)	(6,424)		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	414,375		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 542,954	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,010,223	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 588,683	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,801,816		29
30	Accrued Salaries Payable	202,141		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,221		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	Due to related	1,148,596		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,750,457	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,750,457	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,740,234)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,010,223	$	48

*(See instructions.)

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,528,510)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,528,510)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(211,724)	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)**	$ (211,724)	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)**	$ (1,740,234)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,766,125	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,766,125	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***	464	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 464	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		901	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 901	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,767,490	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,457,170	31
32	Health Care	4,071,407	32
33	General Administration	2,535,135	33
	B. Capital Expense		
34	Ownership	1,351,523	34
	C. Ancillary Expense		
35	Special Cost Centers	823,704	35
36	Provider Participation Fee	740,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,979,214	40
41	**Income before Income Taxes (line 30 minus line 40)****	(211,724)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (211,724)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 2,113,593.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,281,986.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	525,970.00	48
49	Medicare Part A	805,396.00	49
50	Other-(specify) Insurance	473,105.00	50
51	Other-(specify) Med B	566,075.00	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)	$ 10,766,125	56

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,080	$ 121,754	$ 58.54	1
2	Assistant Director of Nursing	1,264	1,337	65,173	48.75	2
3	Registered Nurses	2,924	3,151	137,888	43.76	3
4	Licensed Practical Nurses	40,057	43,501	1,660,912	38.18	4
5	CNAs & Orderlies	76,694	80,871	1,630,725	20.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,117	45,090	21.30	9
10	Activity Assistants	5,431	5,800	88,865	15.32	10
11	Social Service Workers	2,169	2,331	54,154	23.23	11
12	Dietician					12
13	Food Service Supervisor	2,429	2,516	65,107	25.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,489	16,899	275,174	16.28	15
16	Dishwashers					16
17	Maintenance Workers	2,899	3,055	73,728	24.13	17
18	Housekeepers	10,853	11,179	177,471	15.88	18
19	Laundry	3,987	4,335	68,081	15.70	19
20	Administrator	1,904	2,046	127,271	62.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,634	19,164	324,645	16.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,762	1,816	45,086	24.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,347	202,198	$ 4,961,124 *	$ 24.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 21,311	1-3	35
36	Medical Director		18,000	9-3	36
37	Medical Records Consultant		2,376	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		11,677	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		2,250	11-3	44
45	Social Service Consultant		2,250	12-3	45
46	Other(specify) IV Therapy		16,020	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 73,884		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill West	Administrative		$ 35,979
Kim Colbrook	Administrative		16,773
Janice Tabor	Administrative		16,828
Greg Green	Administrative		57,691
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,271

B. Administrative - Other

Description	Amount
Loft Healthcare Mgmt	$ 495,005
TOTAL (agree to Schedule V, line 17, col. 3)	$ 495,005
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KBKB	Accounting	$ 8,200
Plante Moran	Accounting	3,714
RB Health partners	Reimbursement consulting	6,531
Silver Key	Pa Consulting	5,730
MTS Consulting	WOTC	1,180
Correl CO	Retirement consulting	6,619
Ice Miller LLP	Legal	13,751
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,725

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,707
Unemployment Compensation Insurance	70,374
FICA Taxes	407,864
Employee Health Insurance	134,913
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 679,858

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	10,135
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	34,634
Misc Licenses	1,503
Less: Public Relations Expense	( )
PAC and Lobbying payments	(11,545)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,717

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Misc seminars	5,961
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,961

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LOFT REHAB OF ROCK SPRINGS # 0056994 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

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

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

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	23,089
	23,089 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)	11,545
	11,545 Total

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

HEALTH CARE COUNCIL OF IL (HCCI)	34,634
	34,634 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 18,955 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. $ 740,275
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. $

(13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name:

(14) Have all costs which do not relate to the provision of long term care been adjusted out 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.