

		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: <u>0054361</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Loft Rehabilitation Nursing</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>700 N Main Street</u> <u>Eureka</u> <u>61530</u>			
Number City Zip Code			
County: <u>Woodford</u>			
Telephone Number: <u>(309)467-2337</u> Fax # <u>(309)467-9011</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>08/09/2016</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ 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: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(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	

Facility Name & ID Number Loft Rehabilitation Nursing # 0054361 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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	12	Intermediate (ICF)	12	4,380	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	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	4,855	12,119			3,333	1,635	850	22,792	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,855	12,119			3,333	1,635	850	22,792	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 60.04%

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 08/09/2016

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 08/09/2016 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 92

Medicare Intermediary WPS

IV. ACCOUNTING BASIS
ACCRUAL ☒ 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.

STATE OF ILLINOIS

Facility Name & ID Number

Loft Rehabilitation Nursing

0054361

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

Page 3

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	297,804	14,728	8,991	321,523		321,523		321,523			1
2	Food Purchase		186,820		186,820		186,820		186,820			2
3	Housekeeping	85,855	13,370	10,801	110,026		110,026		110,026			3
4	Laundry	41,439	11,594		53,033		53,033		53,033			4
5	Heat and Other Utilities			184,670	184,670		184,670		184,670			5
6	Maintenance	46,717	9,251	83,130	139,098		139,098		139,098			6
7	Other (specify):* Patient Transportation				18,628		18,628		18,628			7
8	TOTAL General Services	471,815	235,763	287,592	1,013,798		1,013,798		1,013,798			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,290,834	97,549	293,731	2,682,114		2,682,114		2,682,114			10
10a	Therapy											10a
11	Activities	100,113	2,904	1,500	104,517		104,517		104,517			11
12	Social Services	36,050		1,750	37,800		37,800		37,800			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,426,997	100,453	308,981	2,836,431		2,836,431		2,836,431			16
	C. General Administration											
17	Administrative	111,299		310,531	421,830		421,830	(175,416)	246,414			17
18	Directors Fees											18
19	Professional Services			72,239	72,239		72,239	9,230	81,469			19
20	Dues, Fees, Subscriptions & Promotions			47,243	47,243		47,243	(22,993)	24,250			20
21	Clerical & General Office Expenses	243,739	31,003	520,487	795,229		795,229	76,559	871,788			21
22	Employee Benefits & Payroll Taxes			431,172	431,172		431,172		431,172			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,274	3,274		3,274		3,274			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			192,500	192,500		192,500	42,699	235,199			26
27	Other (specify):* allocated Benifets							56,057	56,057			27
28	TOTAL General Administration	355,038	31,003	1,577,446	1,963,487		1,963,487	(13,864)	1,949,623			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,253,850	367,219	2,174,019	5,813,716		5,813,716	(13,864)	5,799,852			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			780	780		780	105,158	105,938			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,141	76,141		76,141	103,452	179,593			32
33	Real Estate Taxes							92,073	92,073			33
34	Rent-Facility & Grounds			478,812	478,812		478,812	(473,359)	5,453			34
35	Rent-Equipment & Vehicles							6,403	6,403			35
36	Other (specify):* Mip							22,491	22,491			36
37	TOTAL Ownership			555,733	555,733		555,733	(143,782)	411,951			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,311	315,317	389,628		389,628		389,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			297,033	297,033		297,033		297,033			42
43	Other (specify):* Bad Debt			180,000	180,000		180,000		180,000			43
44	TOTAL Special Cost Centers		74,311	792,350	866,661		866,661		866,661			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,253,850	441,530	3,522,102	7,236,110		7,236,110	(157,646)	7,078,464			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	(74,720)	30		9
10	Interest and Other Investment Income	(198)	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	(151,300)	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				24
25	Fund Raising, Advertising and Promotional	(17,657)	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)	\$ (243,875)		\$	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)	91,565		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 91,565		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (152,310)		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	\$ (5,336)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
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45				45
46				46
47				47
48				48
49	Total	(5,336)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[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	34	Rent	\$ 478,812	Select Post Acute care Realty		\$	(478,812)	1
2	V	30	Depreciation		Select Post Acute care Realty		179,878	179,878	2
3	V	32	Interest	2,072	Select Post Acute care Realty		105,722	103,650	3
4	V	33	Real Estate Tax		Select Post Acute care Realty		92,073	92,073	4
5	V	19	Prof Fees		Select Post Acute care Realty		9,230	9,230	5
6	V	26	Insurance property		Select Post Acute care Realty		42,500	42,500	6
7	V	36	Insurance MIP		Select Post Acute care Realty		22,491	22,491	7
8	V	21	Bank Fees				38	38	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 480,884			\$ 451,932	\$ * (28,952)	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		185,617	185,617	22
23	V	35	Auto		Loft Healthcare Consultants		6,403	6,403	23
24	V	21	Bank Fees		Loft Healthcare Consultants		545	545	24
25	V	27	Health Insurance		Loft Healthcare Consultants		21,210	21,210	25
26	V	27	Pr Taxes		Loft Healthcare Consultants		34,847	34,847	26
27	V	21	Office		Loft Healthcare Consultants		18,340	18,340	27
28	V	26	Insurance		Loft Healthcare Consultants		199	199	28
29	V	34	Rent		Loft Healthcare Consultants		5,453	5,453	29
30	V	21	Telephone		Loft Healthcare Consultants		1,083	1,083	30
31	V								31
32	V	17	Management Fees	310,531	Loft Healthcare Consultants			(310,531)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 310,531			\$ 431,048	\$ * 120,517	39

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

STATE OF ILLINOIS					Ownership Listing-1				
Loft Rehabilitation Nursing									
ID#		0054361							
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)							Management		
-Owners of companies must be listed instead of company names.					Operator/Licensee		Building Co.		
-Names of trust beneficiaries must be listed.					Ownership Percentage		Ownership Percentage		
First Name		M.I.	Last Name	City	State	Ownership Percentage		Ownership Percentage	
1	Susan		Stern	Skokie	IL	4.95000	4.95000		1
2	Esther		Maryles	Chicago	IL	2.47500	2.47500		2
3	Chana		Mauer	Lincolnwood	IL	2.47500	2.47500		3
4	Daniel	J	Aaron	Chicago	IL	18.81100	18.81100	25.00000	4
5	Robert	J	Aaron	Chicago	IL	18.81100	18.81100	25.00000	5
6	Adam	T	Aaron	Lincolnwood	IL	18.81100	18.81100	25.00000	6
7	Michael	B	Aaron	Lincolnwood	IL	18.81200	18.81200	25.00000	7
8									8
9	Berger Family Trust								9
10	Aviva		Berger	Chicago	IL	1.23750	1.23750		10
11	Yosef		Berger	Chicago	IL	1.23750	1.23750		11
12	Yechiel		Berger	Chicago	IL	1.23750	1.23750		12
13	Frayda		Berger	Chicago	IL	1.23750	1.23750		13
14									14
15	Stern Family Investment								15
16	Todd			Skokie	IL	1.23750	1.23750		16
17	Jayden			Skokie	IL	1.23750	1.23750		17
18	Leyla			Skokie	IL	1.23750	1.23750		18
19	Luelle			Skokie	IL	1.23750	1.23750		19
20									20
21	Israel Family Investment Trust								21
22	Benjamin		Israel	Lincolnwood	IL	2.47500	2.47500		22
23									23
24	Israel Investment Trust								24
25	Yehudis		Israel	Lincolnwood	IL	2.47500	2.47500		25
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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 Canton	Canton,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 Decatur	Decatur, IL			Select Post Acute Care	Eureka, IL	Bldg Rental	3
4	The Loft Rehabilitation & Nursing of Rock Spri	Rock Springs, IL						4
5	The Loft Rehabilitation & Nursing of Peoria	Peoria, IL						5
6	The Loft Rehabilitation & Nursing of East Peori	East Peoria, IL						6
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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	18.81	260,439	8	14.00	Alloc wages	\$ 43,407	17-7	1
2	Rober Aaron	Member	Administrative	18.81	261,297	8	14.00	Alloc wages	43,549	17-7	2
3	Adam Aaron	Member	Administrative	18.81	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 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	104	185,617	8
9	35	Auto	Number of beds	895	7	55,102		104	6,403	9
10	21	Bank Fees	Number of beds	895	7	4,687		104	545	10
11	27	Health Insurance	Number of beds	895	7	182,531		104	21,210	11
12	27	Pr Taxes	Number of beds	895	7	299,885		104	34,847	12
13	21	Office	Number of beds	895	7	157,826		104	18,340	13
14	26	Insurance	Number of beds	895	7	1,713		104	199	14
15	34	Rent	Number of beds	895	7	46,930		104	5,453	15
16	21	Telephone	Number of beds	895	7	9,316		104	1,083	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		\$ 431,048	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	Lument Capital		X	Mortgage	\$42,614.00	9/1/16	\$ 4,287,028	\$ 3,288,382	9/1/43	3.0800	\$ 105,722	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	SBA Loan			Working Capital				471,131			76,141	6	
7												7	
8												8	
9	TOTAL Facility Related				\$42,614.00		\$ 4,287,028	\$ 3,759,513			\$ 181,863	9	
	B. Non-Facility Related*												
10	Interest Income Opco										(198)	10	
11	Interest income Propco										(2,072)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,270)	14	
15	TOTALS (line 9+line14)						\$ 4,287,028	\$ 3,759,513			\$ 179,593	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,491 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2024 report.				\$	76,200	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.)				\$	83,273	2
3. Under or (over) accrual (line 2 minus line 1).				\$	7,073	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	85,000	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.				\$	92,073	7
Assessed Value from Real Estate Tax Bill:	2024	1,035,287	8			
Real Estate Tax Bill for Calendar Year:	2020	69,105	9			
	2021	69,665	10			
	2022	71,195	11			
	2023	74,640	12			
	2024	83,273	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

FACILITY NAME Loft Rehabilitation Nursing COUNTY Woodford
FACILITY IDPH LICENSE NUMBER 0054361
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.

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: 42,837 B. General Construction Type: Exterior Brick Frame Brick & Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (X) (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? (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).

F. List the bed capacity for the building if it differs from the licensed total. n/a
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		2016	\$ 37,179	1
2					2
3	TOTALS			\$ 37,179	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	104		2016		\$ 3,001,595	\$	39	\$ 76,964	\$ 76,964	\$ 692,676
5										
6										
7										
8										
	Improvement Type**									
9	Improvements-Landlord		2017		32,210		15	2,147	2,147	19,324
10	Select Care Sign									
11	Hall 6 Medicare Rooms 600-612-New Flooring, Drywall,Wallpaper, Doors,Paint,Light Fixtures,Bathroom Tiles, Fixtures						39	5,825	5,825	52,426
12			2017		227,193					
13	Therapy Room-Flooring,Wallcovering, lighting,Cabinets,Wall Protection									
14			2017		154,298		39	3,956	3,956	35,605
15	Skylight		2017		1,913		39	49	49	441
16	Electrical Work		2017		1,800		39	46	46	414
17	New Ac System		2017		11,000		39	282	282	2,256
18	Pour & Finish Concrete Sidewalk		2018		1,450		39	37	37	296
19	Condensing unit & Coil-Hall 1		2018		11,766		39	302	302	2,415
20	Vinyl Plank Flooring		2018		17,905		39	459	459	3,672
21	40' of Sewer Line Replaced		2018		32,500		39	833	833	6,665
22	Grade Ground to hanle more water capacity		2020		7,600		39	195	195	1,170
23	Install new sections of pipe and fittings		2020		52,500		39	1,346	1,346	8,076
24	Fix floodingof the boiler room and hall 6		2020		5,200		39	133	133	799
25	Wandervision		2021		73,049		39	1,873	1,873	9,365
26	Low serated Stand, reverse acting thermostat		2024		2,408		39	62	62	124
27	New wanderguard system including 26 new keypads and 15 horn alarm		2025		71,197		15	4,746	4,746	4,746
28										
29										
30										
31										
32										
33										
34										
35										
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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replaced shaft and Bearings in hall 4	2022	\$ 1,889	\$	39	\$ 48	\$ 48	\$ 192	37
38	Replaced condensing unit& compressor that serves nurses desk	2022	11,544		39	296	296	1,184	38
39	replace ac unit in hall 3	2022	4,880		39	125	125	500	39
40	Cut out & replace no hub cast iron piping	2022	3,490		39	89	89	356	40
41	Insatll Maglock fire alarm	2022	4,440		39	114	114	456	41
42	Replace gas leak in kitchen a/c	2022	3,422		39	88	88	352	42
43	Bennet Electronic service co	2025	17,153		15	1,144	1,144	1,144	43
44	David Burling Excavating	2025	4,650		15	310	310	310	44
45	Diversified Mechancial	2025	3,501		15	233	233	233	45
46	Russel Ehnle	2025	6,775		15	452	452	452	46
47	Obrien Bro	2025	12,584		15	839	839	839	47
48	Fe Moran	2025	12,500		15	833	833	833	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58				180,658			(180,658)		58
59	Financial Statement Depreciation								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)		\$ 3,792,412	\$ 180,658		\$ 103,828	\$ (76,830)	\$ 847,321	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	\$ 8,866	\$	\$ 887	\$ 887	10	\$ 1,330	71
72	Current Year Purchases	12,233		1,223	1,223	10	1,223	72
73	Fully Depreciated Assets	33,329					33,329	73
74								74
75	TOTALS	\$ 54,428	\$	\$ 2,110	\$ 2,110		\$ 35,882	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)	\$ 3,884,019	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,658	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,938	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (74,720)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 883,203	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:
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:				\$			3
4	Additions							4
5	Allocated rent				5,453			5
6								6
7	TOTAL				\$ 5,453			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?
16. Rental Amount for movable equipment: \$ 6,403 Description: Medical Equipment Rental
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 128,270	\$		\$ 128,270	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,060			20,060	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			166,987			166,987	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				64,224		64,224	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					10,087		10,087	12
13	Other (specify):									13
14	TOTAL			\$		\$ 315,317	\$ 74,311		\$ 389,628	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.

12/31/2025

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,230,753	\$ 2,258,017	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,554	89,554	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,763	4,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,000	32
33	Accrued Interest Payable		8,440	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Others</u>	155,000	155,000	36
37	<u>Due to Others</u>		27,652	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,480,070	\$ 2,628,426	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	471,131	471,131	39
40	Mortgage Payable		3,288,382	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u></u>			43
44	<u></u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 471,131	\$ 3,759,513	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,951,201	\$ 6,387,939	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,475,358)	\$ (2,220,936)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 475,843	\$ 4,167,003	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,996,097)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,996,097)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(479,261)	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)	\$ (479,261)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,475,358)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Loft Rehabilitation Nursing**# **0054361**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	\$ 6,756,651	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,756,651	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***	198	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 198	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)	\$ 6,756,849	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,013,798	31
32	Health Care	2,836,431	32
33	General Administration	1,963,487	33
	B. Capital Expense		
34	Ownership	555,733	34
	C. Ancillary Expense		
35	Special Cost Centers	569,628	35
36	Provider Participation Fee	297,033	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,236,110	40
41	Income before Income Taxes (line 30 minus line 40)**	(479,261)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (479,261)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,191,985.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,998,797.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	868,560.00	48
49	Medicare Part A	1,038,534.00	49
50	Other-(specify) Insurance	439,479.00	50
51	Other-(specify) Med B	219,296.00	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)	\$ 6,756,651	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	2,140	2,369	\$ 126,394	\$ 53.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,506	2,598	126,338	48.63	3
4	Licensed Practical Nurses	20,510	22,195	905,848	40.81	4
5	CNAs & Orderlies	46,538	48,815	1,120,849	22.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,975	2,191	42,557	19.42	9
10	Activity Assistants	3,873	3,961	57,557	14.53	10
11	Social Service Workers	1,306	1,501	36,050	24.02	11
12	Dietician					12
13	Food Service Supervisor	2,134	2,254	63,973	28.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,141	13,840	233,831	16.90	15
16	Dishwashers					16
17	Maintenance Workers	2,099	2,275	46,717	20.53	17
18	Housekeepers	4,992	5,243	85,855	16.38	18
19	Laundry	1,850	2,268	41,439	18.27	19
20	Administrator	1,724	1,829	111,299	60.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,694	9,725	243,739	25.06	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	758	795	11,404	14.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,240	121,859	\$ 3,253,850 *	\$ 26.70	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	\$ 8,991	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant	Monthly	2,372	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,336	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	1,500	11-3	44
45	Social Service Consultant	Monthly	1,750	12-3	45
46	Other(specify) <u>IV Therapy</u>	Monthly	21,570	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,519		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	716	\$ 43,000	10-3	50
51	Licensed Practical Nurses	1,583	87,041	10-3	51
52	Certified Nurse Assistants/Aides	3,292	115,252	10-3	52
53	TOTAL (lines 50 - 52)	5,591	\$ 245,293		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Kimberly Wittenberg	Administrative		\$ 111,299	Workers' Compensation Insurance	\$	60,600	IDPH License Fee	\$	
				Unemployment Compensation Insurance		36,537	Advertising: Employee Recruitment	10,084	
				FICA Taxes		256,732	Health Care Worker Background Check		
				Employee Health Insurance		77,303	(Indicate # of checks performed)		
				Employee Meals			Patient Background Checks	2,645	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	16,008	
							Misc License	849	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,299						
B. Administrative - Other									
Description			Amount						
Loft Hc Management			\$ 310,531						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 310,531						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
KBKB	ACCOUNTING		\$ 8,700			\$	Out-of-State Travel	\$	
Stone Pogrund & Korey	Legal		9,445						
Ice Miller LLP	Legal		44,204						
Plante Moran	Accounting		3,714				In-State Travel		
Personal Planners	SUC Consulting		900						
MTS Consulting	WOTC Consulting		952						
Correl Co	Retirement Consulting		2,574						
The compliance Store	Compliance		1,750				Seminar Expense		
							Misc Seminar	3,274	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 72,239				Entertainment Expense	()	
				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 3,274	

*** 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)	10,672
	10,672 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)	5,336
	5,336 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	16,008
	16,008 Total
- (5)

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

\$	27	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.

\$	297,033
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	None	Has any meal income been offset against related costs?	None	Indicate the amount.	\$	
----	------	--	------	----------------------	----	--
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

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

100

d. Have vehicle usage logs been maintained?

No

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

No

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

No

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (13)

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

No

Firm Name:
- (14)

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

Yes
- (15)

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

Yes

See page 39 of the instructions for details.

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