

		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: 0038646

Facility Name: PARK PLACE CENTRALIA

Address: 332 COUNTRY CLUB RD CENTRALIA 62801

County: MARION

Telephone Number: 618-533-7922 Fax # 61-533-7927

HFS ID Number:

Date of Initial License for Current Owners: 05/15/1993

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501C3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: RENEE ZIEGLER

Telephone Number: 618-533-9633

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 07/01/2024 to 06/30/2025 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) 11/20/2025

(Type or Print Name) CARA STALLARD

(Title) ADMINISTRATOR

Paid Preparer

(Signed) 11/20/2025

(Print Name and Title) RENEE ZIEGLER

(Firm Name & Address) CSI P.O. BOX 1946, CENTRALIA, IL 62801

(Telephone) 618-533-9633 Fax # 618-533-6345

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 PARK PLACE CENTRALIA # 0038646 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS			5,358					5,358	13
14	TOTALS			5,358					5,358	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.75%

D. How many bed reserve days during this year were paid by the Department? 47 (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 5/15/1993

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 5/15/1993 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 7/1/24-6/30/25 Fiscal Year: 7/1/24-6/30/25
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		PARK PLACE CENTRALIA				STATE OF ILLINOIS		#	0038646	Report Period Beginning:		07/01/2024	Ending:	Page 3	06/30/2025
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 1	Supplies 2	Other 3	Total 4					9	10				
	A. General Services					5	6	7	8						
1	Dietary	113,084	4,679	3,963	121,726	10,769	132,495		132,495			1			
2	Food Purchase		54,367		54,367		54,367		54,367			2			
3	Housekeeping		7,388		7,388	32,308	39,696		39,696			3			
4	Laundry		5,961		5,961	21,538	27,499		27,499			4			
5	Heat and Other Utilities			33,895	33,895		33,895		33,895			5			
6	Maintenance		6,904	14,239	21,143		21,143		21,143			6			
7	Other (specify):*											7			
8	TOTAL General Services	113,084	79,299	52,097	244,480	64,615	309,095		309,095			8			
	B. Health Care and Programs														
9	Medical Director			4,000	4,000		4,000		4,000			9			
10	Nursing and Medical Records	663,319	34,211	13,654	711,184	(51,828)	659,356		659,356			10			
10a	Therapy			2,898	2,898		2,898		2,898			10a			
11	Activities	45,095	3,246		48,341	(12,787)	35,554		35,554			11			
12	Social Services	2,568			2,568		2,568		2,568			12			
13	CNA Training											13			
14	Program Transportation		6,061		6,061		6,061		6,061			14			
15	Other (specify):*											15			
16	TOTAL Health Care and Programs	710,982	43,518	20,552	775,052	(64,615)	710,437		710,437			16			
	C. General Administration														
17	Administrative	33,036			33,036		33,036		33,036			17			
18	Directors Fees											18			
19	Professional Services			113,127	113,127		113,127		113,127			19			
20	Dues, Fees, Subscriptions & Promotions			3,382	3,382		3,382		3,382			20			
21	Clerical & General Office Expenses		10,771		10,771		10,771		10,771			21			
22	Employee Benefits & Payroll Taxes			143,130	143,130		143,130		143,130			22			
23	Inservice Training & Education											23			
24	Travel and Seminar			1,740	1,740		1,740		1,740			24			
25	Other Admin. Staff Transportation											25			
26	Insurance-Prop.Liab.Malpractice			20,984	20,984		20,984		20,984			26			
27	Other (specify):*											27			
28	TOTAL General Administration	33,036	10,771	282,363	326,170		326,170		326,170			28			
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	857,102	133,588	355,012	1,345,702		1,345,702		1,345,702			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			26,961	26,961		26,961		26,961			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			377	377		377		377			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			27,338	27,338		27,338		27,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,256	86,256		86,256		86,256			42
43	Other (specify):* BAD DEBTS			2,467	2,467		2,467		2,467			43
44	TOTAL Special Cost Centers			88,723	88,723		88,723		88,723			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	857,102	133,588	471,073	1,461,763		1,461,763		1,461,763			45

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

SALARY ALLOCATION
PARK PLACE - CENTRALIA
YEAR ENDING 6/30/25

		SALARIES PER GL	%	TOTAL HOURS	VACATIONS HRS ETC.
HOUSEKEEPING	\$0.00	\$0.00	0.00%	0.00	0.00
DIRECT CARE	\$20.79	\$617,771.51	93.20%	29716.86	1415.45
ACTIVITY	\$21.98	\$45,095.44	6.80%	2052.00	145.00
SOCIAL SERVICE	\$0.00	\$0.00	0.00%	0.00	0.00
CLERICAL	\$0.00	\$0.00	0.00%	0.00	0.00
	\$20.71	\$662,866.95	100.00%	31768.86	1560.45
		COST REPORT	%	TOTAL HOURS	TOT HOURS WORKED
HOUSEKEEPING	6.00	\$32,307.60	4.87%	1548.39	1472.33
ACTIVITY	6.00	\$32,307.60	4.87%	1548.39	1472.33
LAUNDRY	4.00	\$21,538.40	3.25%	1032.26	981.56
COOK HELPER	2.00	\$10,769.20	1.62%	516.13	490.78
DIRECT CARE		\$565,944.15	85.39%	27123.69	25791.41
		\$662,866.95	100.00%	31768.86	30208.41

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
10	Interest and Other Investment Income				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				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	2,467	43-3		24
25	Fund Raising, Advertising and Promotional				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)	\$ 2,467		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,467		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0038646

Report Period Beginning:07/01/2024

Ending:06/30/2025

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	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	0		49

Summary A

06/30/2025

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

[illegible]

Summary B

Facility Name & ID Number	PARK PLACE CENTRALIA	#	0038646	Report Period Beginning:	07/01/2024	Ending:	06/30/2025
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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
		LYNWOOD ESTATES	SALEM			
		DIAMONDVIEW	CENTRALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 PARK PLACE CENTRALIA # 0038646 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐

NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

Facility Name & ID Number PARK PLACE CENTRALIA # 0038646 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 ☐

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

()

()

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

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

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

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

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

B. Real Estate Taxes

		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.			\$		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.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		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.			\$		7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 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 PARK PLACE CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0038646

CONTACT PERSON REGARDING THIS REPORT RENEE ZIEGLER

TELEPHONE 618-533-9633 FAX #: 618-533-6345

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

B. Real Estate Tax Cost Allocations

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

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2024 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2025 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2024.

Please complete the Real Estate Tax Statement below and include it in the 2025 cost report along with a copy of your 2024 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 524-4489.

FACILITY NAME PARK PLACE CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0038646

CONTACT PERSON REGARDING THIS REPORT RENEE ZIEGLER

TELEPHONE () FAX #: ()

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

5,350

B. General Construction Type:

Exterior

BRICK

Frame

WOOD

Number of Stories

1

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1		50,000	1994	\$ 16,093	1
2				49,883	2
3	TOTALS	50,000		\$ 65,976	3

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	16		1995	1995	\$ 414,491	\$		\$	\$	\$ 414,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO IMPROVEMENTS			1999	6,449					6,449	9
10	24 X 32 PAVILLION			1999	17,486	352	25	352		17,486	10
11	STEEL DOOR			2005	899	36	25	36		722	11
12	SPRINKLER SYSTEM			2010	5,108	312	15	312		5,108	12
13	REMODEL - PAINT, CARPET, TILE ETC			2010	69,504	2,780	25	2,780		40,776	13
14	FURNACE & A/C UNIT			2014	4,300	108	10	108		4,300	14
15	REPLACE FLOORING - BEDROOMS			2015	14,097	564	25	564		5,498	15
16	REPAIR & PAINT BEDROOMS WALLS & 18 DOORS										16
17	REPAIR & PAINT MED ROOM										17
18	REMOVE WALLPAPER & PAINT CEILING - BEDROOMS										18
19	REMOVE WALLPAPER, REPAIR WALL, PAINT										19
20	DINING ROOM, LIVING ROOM, FAMILY ROOM										20
21	OFFICE, NORTH & SOUTH HALLS			2017	12,363	1,264	10	1,264		10,214	21
22	GAS FURNACE			2019	3,225	323	10	323		2,069	22
23	BATHROOM - REFINISH FLOOR,										23
24	SHOWER SURROUND & WALL TILE			2020	3,691	369	10	369		1,784	24
25	ROOF REPLACEMENT			2023	30,679	1,227	25	1,227		2,548	25
26	REPAIR & PAINT - LAUNDRY ROOM										26
27	BATHROOMS, BEDROOMS, DINING ROOM										27
28	KITCHEN, LIVING ROOM, HALLWAYS & OFFICE			2023	6,470	259	25	259		517	28
29	STEEL DOOR			2024	7,220	211	20	211		211	29
30	REPLACE 2 DOORS			2025	4,850	121	20	121		121	30
31	REPLACE A/C UNIT			2025	4,907	20	20	20		20	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 605,739	\$ 7,946		\$ 7,946	\$	\$ 512,314	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	\$ 33,061	\$ 5,627	\$ 5,627	\$	5	\$ 17,350	71
72	Current Year Purchases	21,196	1,379	1,379		5	1,378	72
73	Fully Depreciated Assets	170,086					170,086	73
74								74
75	TOTALS	\$ 224,343	\$ 7,006	\$ 7,006	\$		\$ 188,814	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	PATIENT/ADMIN	2019 DODGE CARAVAN	2019	\$ 42,223	\$ 2,815	\$ 2,815	\$	5	\$ 42,223	76
77	PATIENT/ADMIN	2017 FORD E450 BUS	2021	39,160	7,832	7,832		5	32,633	77
78	PATIENT/ADMIN	2024 CHEVY TRAVERSE	2025	13,618	1,362	1,362		5	1,362	78
79										79
80	TOTALS			\$ 95,001	\$ 12,009	\$ 12,009	\$		\$ 76,218	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 991,059 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,961 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,961 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 777,346 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								5
6								6
7	TOTAL				\$			7

**

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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
		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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,981,922	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	388,906		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,371		6
7	Other Prepaid Expenses	24,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>NON-TRADE A/R</u>	613		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,400,679	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,406		13
14	Buildings, at Historical Cost	1,153,498		14
15	Leasehold Improvements, at Historical Cost	492,160		15
16	Equipment, at Historical Cost	818,138		16
17	Accumulated Depreciation (book methods)	(2,168,159)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	62,889		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 467,932	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,868,611	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,061	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,436		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,345		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	15,335		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 150,177	\$	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)	\$ 150,177	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,718,434	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,868,611	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,560,609	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,560,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,825	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)	\$ 157,825	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)	\$ 3,718,434	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **PARK PLACE CENTRALIA**

0038646

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 1,593,001	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,593,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	141,667	24
25	Interest and Other Investment Income***	28,380	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 170,047	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STAFF TRAINING REIMBURSEMENT	15,586	28
28a	MISCELLANEOUS INCOME	4,277	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,863	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,782,911	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	244,480	31
32	Health Care	775,052	32
33	General Administration	326,170	33
	B. Capital Expense		
34	Ownership	27,338	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	86,256	36
	D. Other Expenses (specify):		
37	BAD DEBTS	2,467	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,461,763	40
41	Income before Income Taxes (line 30 minus line 40)**	321,148	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 321,148	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer	1,372,614.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	40,304.00	48
49	Medicare Part A		49
50	Other-(specify) SOCIAL SECURITY & SSI	180,083.00	50
51	Other-(specify)		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)	\$ 1,593,001	56

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	285	285	9,820	34.46	3
4	Licensed Practical Nurses	96	96	2,404	25.04	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,472	1,548	32,308	20.87	10
11	Social Service Workers	29	29	2,567	88.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	5,442	5,631	123,853	21.99	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,472	1,548	32,308	20.87	18
19	Laundry	982	1,032	21,538	20.87	19
20	Administrator	611	694	33,036	47.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1,173	1,325	33,324	25.15	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,791	27,124	565,944	20.87	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	37,353	39,312	\$ 857,102 *	\$ 21.80	34

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

** See instructions.

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	72	\$ 3,963	1-3	35
36	Medical Director	12	4,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	298	11,473	10-3	38
39	Pharmacist Consultant	12	360	10-3	39
40	Physical Therapy Consultant	495	558	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	36	2,340	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	DENTAL/VISION/PODIATRY	15	1,821	10-3	47
48					48
49	TOTAL (lines 35 - 48)	940	\$ 24,515		49

C. CONTRACT NURSES

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

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 |
|---|---------------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>2,804</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>2,804 Total</u> |
- (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.
- | | |
|---|---------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>Total</u> |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)
- | | |
|---|---------------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>2,804</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>2,804 Total</u> |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 6,864 Line 10-2
- (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. \$ 86,256
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? YES 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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? 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? 90
- 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? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? YES
Firm Name: GLASS & SHUFFETT
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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.

PAGE 21
SECTION 3
LEGAL INVOICES

INVOICE DATE	LAW FIRM	ALLOWABLE AMOUNT	NON- ALLOWABLE AMOUNT	DESCRIPTION OF SERVICES
12/2/2024	CRAIN, MILLER& WERNSMAN, LTD	\$327.44	\$327.44	GUARDIANSHIPS
1/3/2025	CRAIN, MILLER& WERNSMAN, LTD	\$134.46	\$134.46	GUARDIANSHIPS
2/5/2025	CRAIN, MILLER& WERNSMAN, LTD	\$248.69	\$248.69	GUARDIANSHIPS
3/3/2025	CRAIN, MILLER& WERNSMAN, LTD	\$248.00	\$248.00	GUARDIANSHIPS
4/2/2025	CRAIN, MILLER& WERNSMAN, LTD	\$11.25	\$11.25	GUARDIANSHIPS
5/1/2025	CRAIN, MILLER& WERNSMAN, LTD	\$514.60	\$514.60	GUARDIANSHIPS
6/2/2025	CRAIN, MILLER& WERNSMAN, LTD	\$2,436.84	\$2,436.84	GUARDIANSHIPS
6/30/2025	CRAIN, MILLER& WERNSMAN, LTD	\$959.49	\$959.49	GUARDIANSHIPS