

		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: 0056135

Facility Name: Paul House Health Cr Ctr

Address: 3800 N California Chicago 60618
Number City Zip Code

County: Cook

Telephone Number: 773-478-4222 Fax #

HFS ID Number:

Date of Initial License for Current Owners: 12/31/19

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider Telephone Number: 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Paul House Health Cr Ctr # 0056135 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	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	61	Sheltered Care (SC)	61	22,265	5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	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	8,053	4,626	12,988		3,289	2,323	3,423	34,702	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC					5,362			5,362	12
13	DD 16 OR LESS									13
14	TOTALS	8,053	4,626	12,988		8,651	2,323	3,423	40,064	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 64.19%

D. How many bed reserve days during this year were paid by the Department? 0 (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 01/01/20

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 01/01/20 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 110

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Paul House Health Cr Ctr # 0056135 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	456,487	12,220	53,360	522,067		522,067		522,067			1
2	Food Purchase		282,580		282,580		282,580	(1,144)	281,436			2
3	Housekeeping	190,594	21,389	38,045	250,028		250,028		250,028			3
4	Laundry	93,909			93,909		93,909		93,909			4
5	Heat and Other Utilities			375,886	375,886		375,886	2,183	378,069			5
6	Maintenance	127,206		132,751	259,957		259,957	1,918	261,875			6
7	Other (specify):*											7
8	TOTAL General Services	868,196	316,189	600,042	1,784,427		1,784,427	2,957	1,787,384			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,355,692	162,706	1,003,724	4,522,122		4,522,122		4,522,122			10
10a	Therapy											10a
11	Activities	74,929			74,929		74,929		74,929			11
12	Social Services	116,936		13,037	129,973		129,973		129,973			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,547,557	162,706	1,052,761	4,763,024		4,763,024		4,763,024			16
	C. General Administration											
17	Administrative	166,338		1,276,852	1,443,190		1,443,190	(1,266,881)	176,309			17
18	Directors Fees											18
19	Professional Services			199,551	199,551		199,551	8,903	208,454			19
20	Dues, Fees, Subscriptions & Promotions			36,060	36,060		36,060	(12,794)	23,266			20
21	Clerical & General Office Expenses	226,038	35,113	241,670	502,821		502,821	385,139	887,960			21
22	Employee Benefits & Payroll Taxes			600,927	600,927		600,927		600,927			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			48,709	48,709		48,709	(48,709)				25
26	Insurance-Prop.Liab.Malpractice			287,502	287,502		287,502	1,864	289,366			26
27	Other (specify):* Allocated Benefits							26,073	26,073			27
28	TOTAL General Administration	392,376	35,113	2,691,271	3,118,760		3,118,760	(906,405)	2,212,355			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,808,129	514,008	4,344,074	9,666,211		9,666,211	(903,448)	8,762,763			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			293,815	293,815		293,815	114,599	408,414			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							219,152	219,152			32
33	Real Estate Taxes			102,311	102,311		102,311	573,863	676,174			33
34	Rent-Facility & Grounds			792,921	792,921		792,921	(792,921)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			184,174	184,174		184,174	(184,174)				36
37	TOTAL Ownership			1,373,221	1,373,221		1,373,221	(69,481)	1,303,740			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,922	572,331	747,253		747,253		747,253			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			599,670	599,670		599,670		599,670			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		174,922	1,172,001	1,346,923		1,346,923		1,346,923			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,808,129	688,930	6,889,296	12,386,355		12,386,355	(972,929)	11,413,426			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	(225,392)	30		9
10	Interest and Other Investment Income	(15,051)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,144)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(48,709)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(101,089)	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	(184,174)	36		24
25	Fund Raising, Advertising and Promotional	(12,794)	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)	\$ (588,353)		\$	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)	(384,576)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (384,576)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (972,929)		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	\$ 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
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44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34	Rent	\$ 792,921			\$	(792,921)	1
2	V	32	Interest				234,203	234,203	2
3	V	33	Real Estate Tax				566,336	566,336	3
4	V	30	Depreciation				339,991	339,991	4
5	V	21	Office				5,000	5,000	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			\$ 792,921			\$ 1,145,530	\$ * 352,609	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	Management Fees	\$ 1,276,852	Nivram Mgmt Co	100.00%	\$	(1,276,852)	15
16	V	21	Payroll				234,981	234,981	16
17	V	27	Payroll Taxes				26,073	26,073	17
18	V	33	Real Estate Taxes				7,527	7,527	18
19	V	5	Utilities				2,183	2,183	19
20	V	6	Repairs & Maintenance				1,918	1,918	20
21	V	26	Insurance				1,864	1,864	21
22	V	19	Professional Fees				8,903	8,903	22
23	V	21	Office				18,140	18,140	23
24	V	17	Marvin Mermelstein				9,971	9,971	24
25	V	21	Doreen Mermelstein				1,729	1,729	25
26	V	21	Jacob Mermelstein				68,498	68,498	26
27	V	21	Joel Mermelstein				68,646	68,646	27
28	V	21	Jeffrey Mermeklstein				89,234	89,234	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			\$ 1,276,852			\$ 539,667	\$ * (737,185)	39

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

Ownership Listing-2

ID# 0056135

01/01/202

12/31/202

Management

Operator/Licensee

Ownership

Ownership
Percentage

76								76
77								77
78								78
79								79
80								80
81								81
82								82
83								83
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150								150

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	Central Nursing Home	Chicago,IL			3800 N Cal Realty	Lincolnwood	Bldg Rental	1
2	Balmoral Nursing Home	Chicago,IL			Nivram Mgmt Co	Lincolnwood	Mgmt Co	2
3	Winston Manor	Chicago,IL						3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marvin Mermelstein		Admin	90.00	57,831	10	25.00	Salary	\$ 9,971	17	1
2	Doreen Mermelstein		Clerical		10,031	10	25.00	Salary	1,729	21	2
3	Jacob Mermelstein		Clerical		397,288	10	25.00	Salary	68,498	21	3
4	Joel Mermelstein		Clerical		398,145	10	25.00	Salary	68,646	21	4
5	Jeffrey Mermelstein		Clerical		517,557	10	25.00	Salary	89,234	21	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 238,078		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

(847-679-7494

	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	21	Payroll	Resident Beds	748	4	\$ 1,597,872	\$ 1,597,872	110	\$ 234,981	1
2	27	Payroll Taxes	Resident Beds	748	4	177,295		110	26,073	2
3	33	Real Estate Tax	Resident Beds	748	4	51,185		110	7,527	3
4	5	Utilities	Resident Beds	748	4	14,844		110	2,183	4
5	6	Repairs & Maintenance	Resident Beds	748	4	13,043		110	1,918	5
6	26	Insurance	Resident Beds	748	4	12,677		110	1,864	6
7	19	Professional Fees	Resident Beds	748	4	60,541		110	8,903	7
8	21	Office	Resident Beds	748	4	123,350		110	18,140	8
9	17	Marvin Mermelstein	Resident Beds	748	4	67,802	67,802	110	9,971	9
10	21	Doreen Mermelstein	Resident Beds	748	4	11,760	11,760	110	1,729	10
11	21	Jacob Mermelstein	Resident Beds	748	4	465,786	230,442	110	68,498	11
12	21	Joel Mermelstein	Resident Beds	748	4	466,791	231,447	110	68,646	12
13	21	Jeffrey Mermelstein	Resident Beds	748	4	606,791	371,447	110	89,234	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					\$ 3,669,737	\$ 2,510,770		\$ 539,667	25

Facility Name & ID Number Paul House Health Cr Ctr # 0056135 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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	Parkway Bank		X	Mortgage		12/31/19	\$ 3,900,000	\$ 3,744,077			\$ 234,203	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,900,000	\$ 3,744,077			\$ 234,203	9
	B. Non-Facility Related*											
10	Interest Income		X								(15,051)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (15,051)	14
15	TOTALS (line 9+line14)						\$ 3,900,000	\$ 3,744,077			\$ 219,152	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.)

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paul House Health Cr Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056135

CONTACT PERSON REGARDING THIS REPORT Rob Struckoff

TELEPHONE 847-715-2522 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 13-24-115-002-0000		\$ 492,719.19	\$ 492,719.19
2.		\$	\$
3.		\$	\$
4. Allocated from Mgmt Co:		\$	\$
5. 10-35-325-015-0000		\$ 43,099.76	\$ 6,338.00
6. 10-35-325-029-0000		\$ 8,084.94	\$ 1,189.00
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 543,903.89	\$ 500,246.19

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:91,138

B. General Construction Type:ExteriorBrickFrameBrick

Number of Stories4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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)?

YESNO

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

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

☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred:

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	Facility		2020	\$600,000	1
2					2
3	TOTALS			\$600,000	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	110		2020		\$ 4,800,000	\$ 241,818	27.5	\$ 174,545	\$ (67,273)	\$ 1,047,270
5										
6										
7										
8										
	Improvement Type**									
9	New Roof-Champion Roofing			2020	73,900		15	4,927	4,927	29,562
10	Elevator Repair-Colley Elevator			2020	7,048		15	470	470	2,820
11	Earley Insulation-New Insulation & Asbestos Removal			2020	18,000		15	1,200	1,200	7,200
12	Iteleco-New Phone System			2020	14,000		15	933	933	5,598
13	Procom Enterprises-Security System			2020	5,908		15	394	394	2,364
14										
15	Champion Roofing-New Roof			2021	96,400		15	6,457	6,457	32,285
16	McQuay Chiller Sysyem Compressor Replacement			2022	28,242		15	1,883	1,883	7,532
17	Fire Alarm Installation			2022	30,000		15	2,000	2,000	8,000
18	New Elevator Controller & Fix. Door Operator			2022	64,802		15	4,320	4,320	12,960
19	New Elevator Cylinder Hole Clause			2022	41,826		15	2,788	2,788	8,364
20										
21										
22	Installation of Tile in 1st & 2nd Floor			2023	44,564		15	2,971	2,971	8,913
23	Prep & Install Wall & Floor Tile in 1st Floor Resident Bathrooms			2023	4,088		15	273	273	819
24	Replace Lighting in 1st & 2nd Floor Corridors			2023	38,341		15	2,556	2,556	7,668
25	Remove & Replace Handrail & Bumper in 1st & 2nd Floor Corridors			2023	27,698		15	1,847	1,847	5,541
26	Replace Sinks & Faucets in 1st Floor Bathrooms			2023	5,006		15	334	334	1,002
27	Replace Existing Nurse Call System with New Wireless System			2023	25,700		15	1,713	1,713	5,139
28	Installed Boiler			2023	6,722		15	448	448	1,344
29	Installation of New Chilled Water/Heating Replacement Coil			2023	35,980		15	2,399	2,399	7,197
30	Repair Leak in Chiller Refrigerant Circuit			2023	11,575		15	772	772	2,316
31	Install Elevator Heavy duty Lockable Disconnect			2023	19,000		15	1,267	1,267	3,801
32	Water Heater Replacement			2023	33,000		15	2,200	2,200	6,600
33	Sprinkler system Work in Elevator Shaft			2023	25,880		15	1,725	1,725	5,175
34	Repair Leaking Water Heater Pipe			2023	3,480		15	232	232	696
35	Replace All Pumps & Gaskets for Compressors			2023	11,068		15	738	738	2,214
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Paul House Health Cr Ctr

0056135

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	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	Colley Elevator-New Elevator in Building	2023	\$ 387,366	\$	15	\$ 25,824	\$ 25,824	\$ 77,472	37
38	Connor-Elevator Upgrades	2023	9,625		15	642	642	1,926	38
39	Firetek-Fire Alarms & Equipment	2023	55,856		15	3,724	3,724	11,172	39
40	Lionheart-Generator	2023	9,107		15	607	607	1,821	40
41	Remove & Replace Flooring with PVY,Millwork or Cove Base	2023	283,117		15	18,874	18,874	56,622	41
42	in 1st 2nd Floor Corridor,1st 2nd Floor Res Rooms, 2nd Floor								42
43	Dining Room								43
44									44
45	Paint & Prep Walls & Doors in 2nd Floor Corridors Res Rooms	2023	243,426		15	16,228	16,228	48,684	45
46	Dining Room,Admin Office,Guest Bathroom & Corridor,Family								46
47	Room,Therapy Rooms,1st & 2nd Floor Res Rooms, 1st & 2nd Floo								47
48	Res Bathrooms,First Floor Corridor								48
49	2024 Improvements								49
50	Replacement Call Light System-2nd Floor	2024	18,055		15	1,204	1,204	2,408	50
51	Roofing Repair SW Corner	2024	6,625		15	442	442	884	51
52	Insulate HVAC Piping & Pump	2024	6,725		15	448	448	896	52
53	Fire Alarm Elevator Upgrade	2024	131,915		15	8,794	8,794	17,588	53
54	Ground & Repoint Loose Mortar-Replace Damaged Brick	2024	58,000		15	3,867	3,867	7,734	54
55	Replace Conveyer Drive Dishwasher	2024	3,707		15	247	247	494	55
56	Install 2 New Boiler Reset Controller	2024	7,000		15	467	467	934	56
57	Replacement of Damaged Hydronic Coils on Roof	2024	19,900		15	1,327	1,327	2,654	57
58	Install 2 100 Gallon Heaters	2024	12,500		15	833	833	1,666	58
59	Install New Chiller on Roof	2024	121,800		15	8,120	8,120	16,240	59
60	Install 6 Cubicle Tracks with Curtain	2024	2,629		15	175	175	350	60
61	New Ceiling & Wall Surfaces in Resident rooms	2024	43,807		15	2,920	2,920	5,840	61
62	Replace Failed FDC Piping Found During Failed Hydrostatic Test	2025	10,786		15	719	719	719	62
63	Remove Internal Wiring on 2 Transfer Switches & Replace	2025	25,000		15	1,667	1,667	1,667	63
64	Replace Leaking Hot Water Storage Tank for Laundry	2025	5,500		15	367	367	367	64
65	Furnish & Install Shipco 20LRV Vacuum Pump	2025	61,400		15	4,093	4,093	4,093	65
66	Furnish & Install New Weil McLain 88 Series Boiler	2025	77,000		15	5,133	5,133	5,133	66
67	Install 3 New ClimaCool Chiller Modules	2025	80,000		15	5,333	5,333	5,333	67
68									68
69	Financial Statement Depreciation			391,988			(391,988)		69
70	TOTAL (lines 4 thru 69)		\$ 7,153,074	\$ 633,806		\$ 331,447	\$ (302,359)	\$ 1,495,077	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	\$769,673	\$	\$76,967	\$76,967	10	\$426,245	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$769,673	\$	\$76,967	\$76,967		\$426,245	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)	\$8,522,747	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$633,806	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$408,414	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(225,392)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,921,322	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: N/A
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

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	\$

* 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.

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			572,331			572,331	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				174,922		174,922	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 572,331	\$ 174,922		\$ 747,253	14

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 424,515	\$ 424,515	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,798,694	1,798,694	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,705	77,705	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		196,400	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,300,914	\$ 2,497,314	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		4,800,000	14
15	Leasehold Improvements, at Historical Cost	4,185,406	4,185,406	15
16	Equipment, at Historical Cost	100,729	700,729	16
17	Accumulated Depreciation (book methods)	(3,895,724)	(6,420,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 390,411	\$ 3,865,192	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,691,325	\$ 6,362,506	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,911,291	\$ 3,911,291	26
27	Officer's Accounts Payable	318,090	318,090	27
28	Accounts Payable-Patient Deposits	36,729	36,729	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,609	229,609	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,840	18,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		517,355	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Acc Mgmt Fee</u>	904,212	904,212	36
37	<u>Due to Prior Owner</u>	383,847	383,847	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,802,618	\$ 6,319,973	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,744,077	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)	\$	\$ 3,744,077	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,802,618	\$ 10,064,050	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,111,293)	\$ (3,701,544)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,691,325	\$ 6,362,506	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,351,182)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,351,182)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,739,889	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	(1,500,000)	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)	\$ 239,889	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)	\$ (3,111,293)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Paul House Health Cr Ctr

0056135

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	\$ 14,111,193	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,111,193	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***	15,051	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,051	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)	\$ 14,126,244	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,784,427	31
32	Health Care	4,763,024	32
33	General Administration	3,118,760	33
	B. Capital Expense		
34	Ownership	1,373,221	34
	C. Ancillary Expense		
35	Special Cost Centers	747,253	35
36	Provider Participation Fee	599,670	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,386,355	40
41	Income before Income Taxes (line 30 minus line 40)**	1,739,889	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,739,889	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,755,552.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,361,162.00	45
46	MMAI-Medicaid is the Primary Payer	3,821,860.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,347,685.00	48
49	Medicare Part A	1,867,122.00	49
50	Other-(specify) Medicare-B	360,349.00	50
51	Other-(specify) Medicare Replacement	1,221,353.00	51
52	Other-(specify) Insurance	376,110.00	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)	\$ 14,111,193	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	2,073	2,389	\$ 197,373	\$ 82.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,541	8,234	369,794	44.91	3
4	Licensed Practical Nurses	27,774	29,069	1,094,415	37.65	4
5	CNAs & Orderlies	60,661	64,862	1,533,643	23.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,178	1,342	34,800	25.93	9
10	Activity Assistants	1,854	2,221	40,129	18.07	10
11	Social Service Workers	3,279	3,374	116,936	34.66	11
12	Dietician					12
13	Food Service Supervisor	1,453	1,468	58,400	39.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,157	22,191	398,087	17.94	15
16	Dishwashers					16
17	Maintenance Workers	4,222	4,511	127,206	28.20	17
18	Housekeepers	10,628	11,223	190,594	16.98	18
19	Laundry	4,965	5,303	93,909	17.71	19
20	Administrator	2,080	2,184	166,338	76.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,224	7,516	226,038	30.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,891	2,083	52,601	25.25	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,792	1,811	107,866	59.56	33
34	TOTAL (lines 1 - 33)	159,772	169,781	\$ 4,808,129 *	\$ 28.32	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	\$ 53,360	1-3	35
36	Medical Director	Monthly	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	24,990	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	13,037	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 127,387		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,754	\$ 113,990	10-3	50
51	Licensed Practical Nurses	9,115	546,928	10-3	51
52	Certified Nurse Assistants/Aides	9,080	317,816	10-3	52
53	TOTAL (lines 50 - 52)	19,949	\$ 978,734		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Ayo Adegoye	Administrator	0	\$ 76,923
Katie Dewerdt	Administrator	0	28,538
Maivette Gleason	Administrator	0	38,077
Gerald Imperial	Administrator	0	22,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 166,338
B. Administrative - Other			
Description			Amount
Nivram Mgmt-Mgmt Fees			\$ 1,276,852
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,276,852
C. Professional Services			
Vendor/Payee	Type		Amount
Mendel Schneider CPA	Accounting		\$ 18,200
Gary Weintraub	Legal		38,285
Fred Berkovits	Legal		2,610
Garnett SNF	Reimbursement Cons		68,546
GCHMO	Case Mgmt		36,404
Property Valuation Svc	Appraisal		2,900
Achieve Accreditation	Accreditation Support		10,080
Integra	Nursing Cond		9,136
US Nursing Plus	Nurse Recruiter		13,390
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 199,551
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 75,340
Unemployment Compensation Insurance			76,156
FICA Taxes			352,600
Employee Health Insurance			96,831
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 600,927
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			1,850
Patient Background Checks			2,806
Association Dues (total from pg 22, #4)			
Joint Commission			6,855
Netsmart			5,988
Accurate Biometrics			3,777
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,266
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			\$

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name	Amount
	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.

	Total
- (4)

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

	Total
- (5)

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

\$ 11,000

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.

\$ 599,670

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.

\$

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?

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?

d. Have vehicle usage logs been maintained?

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

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

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

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?

See page 39 of the instructions for details.

Yes

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