

		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: 0054981

Facility Name: Radford Green

Address: 960 Audobon Way Lincolnshire 60069
Number City Zip Code

County: Lake

Telephone Number: '847-876-2401 Fax # 847-876-2402

HFS ID Number:

Date of Initial License for Current Owners: 12/02/2018

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: Patrick Carroll Telephone Number: +1(414) 259-6792
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)
(Type or Print Name) Tim Braband
(Title) Director of Finance

Paid Preparer

(Signed)
(Print Name and Title) Patrick Carroll Senior Manager
(Firm Name & Address) Wipfli Advisory LLC Milwaukee
(Telephone) +1(414) 259-6792 Fax # ()

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

Radford Green

#

0054981

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	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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	469				11,225	12,550	4,152	28,396	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	469				11,225	12,550	4,152	28,396	14

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

92.62%

D. How many bed reserve days during this year were paid by the Department?

112 (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)

Assisted Living, Independent Living, Clinic & Home Health

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 11/18/2010

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/18/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 84

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	751,072	84,062	3,995	839,129		839,129		839,129			1
2	Food Purchase		597,000		597,000		597,000		597,000			2
3	Housekeeping	212,715	29,620	24,950	267,285		267,285		267,285			3
4	Laundry	29,062			29,062		29,062		29,062			4
5	Heat and Other Utilities			84,817	84,817		84,817		84,817			5
6	Maintenance	69,510	6,387	74,949	150,846		150,846	(12,963)	137,883			6
7	Other (specify):*											7
8	TOTAL General Services	1,062,359	717,069	188,711	1,968,139		1,968,139	(12,963)	1,955,176			8
	B. Health Care and Programs											
9	Medical Director			45,100	45,100		45,100		45,100			9
10	Nursing and Medical Records	6,223,535	30,166	1,195,977	7,449,678		7,449,678		7,449,678			10
10a	Therapy	1,400,452			1,400,452		1,400,452		1,400,452			10a
11	Activities	597,431	35,522	154,239	787,192		787,192		787,192			11
12	Social Services	179,459			179,459		179,459		179,459			12
13	CNA Training			1,722	1,722		1,722		1,722			13
14	Program Transportation			1,759	1,759		1,759		1,759			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,400,877	65,688	1,398,797	9,865,362		9,865,362		9,865,362			16
	C. General Administration											
17	Administrative	131,665	11,950	764,338	907,953		907,953	(519,631)	388,322			17
18	Directors Fees											18
19	Professional Services			29,332	29,332		29,332		29,332			19
20	Dues, Fees, Subscriptions & Promotions			874	874		874		874			20
21	Clerical & General Office Expenses	103,615	203	551,247	655,065		655,065	(16,716)	638,349			21
22	Employee Benefits & Payroll Taxes			2,357,236	2,357,236		2,357,236		2,357,236			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,222	11,222		11,222	(11,222)				24
25	Other Admin. Staff Transportation			180	180		180		180			25
26	Insurance-Prop.Liab.Malpractice			25,360	25,360		25,360		25,360			26
27	Other (specify):*											27
28	TOTAL General Administration	235,280	12,153	3,739,789	3,987,222		3,987,222	(547,569)	3,439,653			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,698,516	794,910	5,327,297	15,820,723		15,820,723	(560,532)	15,260,191			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			6,892,772	6,892,772		6,892,772	(6,474,082)	418,690			30
31	Amortization of Pre-Op. & Org.			77,093	77,093		77,093		77,093			31
32	Interest			3,464,833	3,464,833		3,464,833	(3,464,833)				32
33	Real Estate Taxes			328,400	328,400		328,400		328,400			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,464	16,464		16,464		16,464			35
36	Other (specify):*											36
37	TOTAL Ownership			10,779,562	10,779,562		10,779,562	(9,938,915)	840,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			790,760	790,760		790,760		790,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	10,602		16,034	26,636		26,636		26,636			41
42	Provider Participation Fee			210,878	210,878		210,878		210,878			42
43	Other (specify):*			26,351,271	26,351,271		26,351,271	(26,351,271)	(0)			43
44	TOTAL Special Cost Centers	10,602		27,368,943	27,379,545		27,379,545	(26,351,271)	1,028,274			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	9,709,118	794,910	43,475,802	53,979,830		53,979,830	(36,850,718)	17,129,112			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	(12,963)	6		5
6	Rented Facility Space	(4,374)	17		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	(210,465)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,022)	21		13
14	Non-Care Related Interest	(3,254,368)	32		14
15	Non-Care Related Owner's Transactions	(6,474,082)	30		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				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	(26,365,159)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,327,433)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(512,063)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (512,063)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (36,839,496)		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	0	0	2
3	Other Income	(10,694)	21	3
4	Flowers & Memorials	(2,308)	17	4
5	Non SNF Expenses(AL,IL & Marketing)	(26,351,271)	43	5
6	Guest Room	(886)	17	6
7	Marketing travel	(11,222)	24	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	(26,376,381)		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
Senior Living Operators (SL-VII) LLC.	100	Monarch Landing	Monarch Landing	Arcapita, LLC	Harrison, NY	Development Co.

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	17	Management Fees	\$ 512,063	Senior Care Arcapita, LLC	100.00%	\$	\$ (512,063)	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			\$ 512,063			\$	\$ *	(512,063) 14

* 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 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								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 Radford Green # 0054981 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

Facility Name & ID Number Radford Green # 0054981 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	BMO Harris		X		Yes	08/03/2018	\$ 51,000,000	\$ 48,105,111	08/03/2027	6.4800	\$ 3,464,833	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 51,000,000	\$ 48,105,111			\$ 3,464,833	9	
	B. Non-Facility Related*												
10	Interest Income											10	
11	Non-Allowable (Rate Swap)											11	
12	Non-Allowable (Non-Care)										(3,254,368)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,254,368)	14	
15	TOTALS (line 9+line14)						\$ 51,000,000	\$ 48,105,111			\$ 210,465	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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$130,470	2
3. Under or (over) accrual (line 2 minus line 1).				\$130,470	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$197,930	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.				\$	6
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.				\$328,400	7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 1,069,699 9					
2021 1,124,169 10					
2022 2,247,209 11					
2023 2,174,710 12					
2024 2,147,888 13					
				14	14
				15	15
				16	16
				17	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 107,394 B. General Construction Type: Exterior Brick Frame Steel and Concrete Number of Stories 3

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).
Independent Living (467 Units)
Assisted Living (44 Units)
Clinic
Home Health

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 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	
Use		Square Feet		Year Acquired		Cost	
1	Land			2010	\$	715,553	1
2							2
3	TOTALS				\$	715,553	3

Facility Name & ID Number Radford Green

0054981

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	84		2010	2010	\$ 12,111,778	\$ 305,102	25 to 40	\$ 305,102	\$	\$ 2,280,033	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements (see detailed subschedule			2018	4,504,419	13,928		13,928		(103,116)	9
10	Improvements (see detailed subschedule			2019	983,610	4,080		4,080		(26,850)	10
11	Improvements (see detailed subschedule			2020	656,359	2,729		2,729		(15,679)	11
12	Improvements (see detailed subschedule			2021	557,835	2,226		2,226		(9,650)	12
13	Improvements (see detailed subschedule			2022	2,562,354	10,334		10,334		(35,419)	13
14	Improvements (see detailed subschedule			2023	2,586,467	10,432		10,432		(27,225)	14
15	Improvements (see detailed subschedule			2024	2,874,111	11,612		11,612		(18,164)	15
16	Improvements (see detailed subschedule			2025	4,850,250	11,752		11,752		(11,752)	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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)		\$ 31,687,181	\$ 372,195		\$ 372,195	\$ 2,032,178	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	\$492,053	\$46,195	\$46,195	\$	10	\$288,238	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$492,053	\$46,195	\$46,195	\$		\$288,238	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				\$4,768	\$299	\$299	\$	5	\$4,768	76
77										77
78										78
79										79
80	TOTALS			\$4,768	\$299	\$299	\$		\$4,768	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)	\$32,899,555	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$418,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$418,689	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)	\$2,325,184	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	Building	\$187,432,114	\$4,717,725	\$35,255,643	86
87	Equipment	7,608,511	714,299	4,456,969	87
88	Vehicle	73,732	4,618	73,732	88
89	Improvements - Building and Land	18,386,333	1,037,440	3,832,534	89
90	Land	11,064,447			90
91	TOTALS	\$224,565,137	\$6,474,082	\$43,618,878	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☒ X NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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
		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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,530,959	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	9,617,902		3
4	Supply Inventory (priced at)	86,056		4
5	Short-Term Investments			5
6	Prepaid Insurance	969,157		6
7	Other Prepaid Expenses	69,578		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	553,315		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,826,967	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,780,000		13
14	Buildings, at Historical Cost	199,553,615		14
15	Leasehold Improvements, at Historical Cost	19,575,403		15
16	Equipment, at Historical Cost	8,179,065		16
17	Accumulated Depreciation (book methods)	(46,439,772)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	9,182,988		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,560,299)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	347,783		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,618,783	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 217,445,750	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,130,810	\$	26
27	Officer's Accounts Payable	528,092		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,596,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	186,693		31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,292,156		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Derivative Instrument /Wait list & Deposit	48,000		36
37	Accrued Expenses	1,163,981		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,946,049	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	48,105,111		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Attrition	193,492,101		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 241,597,212	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 249,543,261	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (32,097,511)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 217,445,750	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (27,258,839)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (27,258,839)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,859,967)	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	21,295	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)	\$ (4,838,672)	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)	\$ (32,097,511)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Radford Green

0054981

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	\$ 16,289,699	1
2	Discounts and Allowances for all Levels	(3,659,321)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,630,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,327,054	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,327,054	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	4,374	16
17	Sale of Drugs	619,903	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	135,823	19
20	Radiology and X-Ray	38,605	20
21	Other Medical Services	123,848	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 922,553	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent & Assisted Living	29,605,566	28
28a	Other Income	1,634,312	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,239,878	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 49,119,863	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,968,139	31
32	Health Care	9,865,362	32
33	General Administration	3,987,222	33
	B. Capital Expense		
34	Ownership	10,779,562	34
	C. Ancillary Expense		
35	Special Cost Centers	27,168,667	35
36	Provider Participation Fee	210,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 53,979,830	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,859,967)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,859,967)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 141,387.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	6,387,028.00	48
49	Medicare Part A	5,364,516.00	49
50	Other-(specify)	737,447.00	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)	\$ 12,630,378	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	4,208	4,208	\$ 142,054	\$ 33.76	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	58,439	61,396	2,466,842	40.18	3
4	Licensed Practical Nurses	31,971	33,648	820,629	24.39	4
5	CNAs & Orderlies	135,952	145,604	2,679,888	18.41	5
6	CNA Trainees			0		6
7	Licensed Therapist	34,057	34,057	1,400,452	41.12	7
8	Rehab/Therapy Aides			0		8
9	Activity Director	23,155	23,155	611,049	26.39	9
10	Activity Assistants			0		10
11	Social Service Workers	5,413	5,685	165,841	29.17	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	6,047	6,047	173,500	28.69	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	20,501	20,501	588,174	28.69	15
16	Dishwashers			0		16
17	Maintenance Workers	3,089	3,089	69,510	22.50	17
18	Housekeepers	11,022	11,022	212,715	19.30	18
19	Laundry	1,733	1,733	29,062	16.77	19
20	Administrator			0		20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	8,258	8,258	234,534	28.40	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified ID Prof (QIDP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	2,639	2,639	114,122	43.24	31
32	Other Health Care(specify)			0		32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	346,485	361,043	\$ 9,708,372 *	\$ 26.89	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		\$ 61,361	1-3	35
36	Medical Director		45,100	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		36,000	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 142,461		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	12,901	454,748	10-3	52
53	TOTAL (lines 50 - 52)	12,901	\$ 454,748		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Tamara Solari	Administrator		\$ 131,665
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 131,665
B. Administrative - Other			
Description			Amount
Recruiting, Orientation, Training & Employee Amenities			\$ 13,313
Flowers & Memorials, Office Wide Functions, Consultants			6,396
Management Fees, Salaries & Benefits - LCS Employees, Board Expenses			744,629
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 764,338
C. Professional Services			
Vendor/Payee	Type		Amount
Hinckley Allen & Snyder LLP	Legal Fees		\$ 10,631
Patrick Hanlon	Property Tax work		
Jackson Lewis	Audit fees		16,422
WIPFLI	Cost Report Preparation		2,279
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 29,332
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 132,706
Unemployment Compensation Insurance			48,332
FICA Taxes			773,163
Employee Health Insurance			1,247,563
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401K Expense			149,025
Employee Benefit			6,447
TOTAL (agree to Schedule V, line 22, col.8)			\$ 2,357,236
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			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks License			
Dues & Subscription			874
Marketing			
Less: Public Relations Expense	(	)	
PAC and Lobbying payments	(	)	
All non-allowable advertising	(	)	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 874
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)			
TOTAL			\$

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

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

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
	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.

\$ Line
- (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.

\$ 210,878

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.

\$ No Has any meal income been offset against related costs? No Indicate the amount. \$
- (12) Travel and Transportation

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

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. \$ N/A

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

No

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?

Yes

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. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: Beers, Hammerman, Cohen & Berger PC
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?

Yes

See page 39 of the instructions for details.

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