

		FOR BHF USE					

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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: 0033936

Facility Name: Seborg Terrace

Address: 3024 Alida Street Rockford 61103
Number City Zip Code

County: Winnebago

Telephone Number: (815) 963-0332 Fax # (815) 963-4668

HFS ID Number:

Date of Initial License for Current Owners: 07/01/88

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Brian Burger Telephone Number: (309) 343-1550
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 4/1/2024 to 3/31/2025 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) Brian Burger
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace # 0033936 Report Period Beginning: 4/1/2024 Ending: 3/31/2025

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	4,436							4,436	13
14	TOTALS	4,436							4,436	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 75.96%

D. How many bed reserve days during this year were paid by the Department? 46 (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 07/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/26/1990 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 3/31/2025 Fiscal Year: 3/31/2025

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

Facility Name & ID Number		Seborg Terrace		STATE OF ILLINOIS		#	0033936	Report Period Beginning:		4/1/2024	Ending:		Page 3	3/31/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)														
	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY				
		Salary/Wage	Supplies	Other	Total					9	10			
	A. General Services	1	2	3	4	5	6	7	8	9	10			
1	Dietary	38,471	4,998	2,417	45,886		45,886		45,886			1		
2	Food Purchase		53,344		53,344		53,344		53,344			2		
3	Housekeeping	22,677	4,363	240	27,280		27,280		27,280			3		
4	Laundry		5,775		5,775		5,775		5,775			4		
5	Heat and Other Utilities			15,147	15,147		15,147		15,147			5		
6	Maintenance	17,366	10,878	22,389	50,633		50,633		50,633			6		
7	Other (specify):* Waste Disposal											7		
8	TOTAL General Services	78,514	79,358	40,193	198,065		198,065		198,065			8		
	B. Health Care and Programs													
9	Medical Director			1,071	1,071		1,071		1,071			9		
10	Nursing and Medical Records	355,243	8,315	12,044	375,602		375,602		375,602			10		
10a	Therapy											10a		
11	Activities		668	1,112	1,780		1,780		1,780			11		
12	Social Services											12		
13	CNA Training	10,218			10,218		10,218		10,218			13		
14	Program Transportation			5,256	5,256		5,256		5,256			14		
15	Other (specify):*											15		
16	TOTAL Health Care and Programs	365,461	8,983	19,483	393,927		393,927		393,927			16		
	C. General Administration													
17	Administrative	9,499			9,499		9,499		9,499			17		
18	Directors Fees							1,091	1,091			18		
19	Professional Services			65,947	65,947		65,947	1,002	66,949			19		
20	Dues, Fees, Subscriptions & Promotions			6,109	6,109		6,109	(215)	5,894			20		
21	Clerical & General Office Expenses	28,901	2,518	8,315	39,734		39,734		39,734			21		
22	Employee Benefits & Payroll Taxes			75,745	75,745		75,745		75,745			22		
23	Inservice Training & Education			4,108	4,108		4,108		4,108			23		
24	Travel and Seminar			561	561		561		561			24		
25	Other Admin. Staff Transportation			2,122	2,122		2,122		2,122			25		
26	Insurance-Prop.Liab.Malpractice			7,006	7,006		7,006	847	7,853			26		
27	Other (specify):*											27		
28	TOTAL General Administration	38,400	2,518	169,913	210,831		210,831	2,725	213,556			28		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	482,375	90,859	229,589	802,823		802,823	2,725	805,548			29		

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

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			15,791	15,791		15,791	(377)	15,414			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			15,791	15,791		15,791	(377)	15,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,933	57,933		57,933		57,933			42
43	Other (specify):* Disallowed Costs			8,183	8,183		8,183	(8,183)				43
44	TOTAL Special Cost Centers			66,116	66,116		66,116	(8,183)	57,933			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	482,375	90,859	311,496	884,730		884,730	(5,835)	878,895			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(377)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,766)	43		24
25	Fund Raising, Advertising and Promotional	(417)	43		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 See Page 5A	(224)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,784)		\$	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)	2,949		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,949		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (5,835)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (224)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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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	(224)		49

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
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Frances House, Inc.	100.00%	\$ 1,091	\$ 1,091	1
2	V	19	Professional Services		Frances House, Inc.	100.00%	1,002	1,002	2
3	V	26	Property Insurance		Frances House, Inc.	100.00%	847	847	3
4	V	20	Dues, Fees & Subscriptions		Frances House, Inc.	100.00%	9	9	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			\$			\$ 2,949	\$ * 2,949	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seborg Terrace# 0033936

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Hawthorne Inn of Danville</u>	<u>Danville</u>				1
2	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Clinton-Sold 3/5/25</u>	<u>Clinton</u>				2
3	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Freeport</u>	<u>Freeport</u>				3
4	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Peoria</u>	<u>Peoria</u>				4
5	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Peru</u>	<u>Peru</u>				5
6	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Princeton</u>	<u>Princeton</u>				6
7	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Freeport, IL</u>	<u>Freeport, IL</u>	<u>Supportive Living Facility</u>	7
8	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Peoria, IL</u>	<u>Peoria, IL</u>	<u>Assisted Living Facility</u>	8
9	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Hawthorne Inn of Peru, IL</u>	<u>Peru, IL</u>	<u>Assisted Living Facility</u>	9
10	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Geneseo, IL</u>	<u>Geneseo, IL</u>	<u>Asst'd & Ind Living</u>	10
11	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Streator, IL</u>	<u>Streator, IL</u>	<u>Asst'd & Ind Living</u>	11
12	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Danville, IL</u>	<u>Danville, IL</u>	<u>Ind Living Facility</u>	12
13	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Freeport, IL</u>	<u>Freeport, IL</u>	<u>Ind Living Facility</u>	13
14	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Peoria, IL</u>	<u>Peoria, IL</u>	<u>Ind Living Facility</u>	14
15	<u>Residential Alternatives of Illinois</u>	<u>100%</u>			<u>Liberty Estates of Peru, IL</u>	<u>Peru, IL</u>	<u>Ind Living Facility</u>	15
16	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Windmill Manor</u>	<u>Coralville, IA</u>				16
17	<u>Residential Alternatives of Illinois</u>	<u>100%</u>	<u>Manor Court of Rochelle</u>	<u>Rochelle</u>	<u>Hawthorne Inn of Rochelle, IL</u>	<u>Rochelle, IL</u>	<u>Assisted Living Facility</u>	17
18	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Casa Willis</u>	<u>Sterling, IL</u>	<u>Woodburn</u>	<u>Sterling, IL</u>	<u>CILA</u>	18
19	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Freeport Terrace</u>	<u>Freeport, IL</u>				19
20	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Gordon Jones Terrace</u>	<u>Lanark, IL</u>				20
21	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Hallam Terrace</u>	<u>Rockford, IL</u>				21
22	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Hammett House</u>	<u>Sterling, IL</u>				22
23	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Kanthak House</u>	<u>Ottawa, IL</u>				23
24	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Olson Terrace</u>	<u>Rockford, IL</u>				24
25	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Ridge Terrace</u>	<u>Freeport, IL</u>				25
26	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Cantebury Place</u>	<u>Rockford, IL</u>				26
27	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Glenwood Villa</u>	<u>Rockford, IL</u>				27
28	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Rockton Court</u>	<u>Rockford, IL</u>				28
29	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Rose House</u>	<u>Moline, IL</u>				29
30	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Seborg Terrace</u>	<u>Rockford, IL</u>				30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seborg Terrace# 0033936

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Frances House, Inc.	100%	Smith Square	Moline, IL				1
2	Frances House, Inc.	100%	Stern Square	Sterling, IL				2
3	Frances House, Inc.	100%	Stouffer Terrace	Oregon, IL				3
4	Frances House, Inc.	100%	Lewis Terrace	North Chicago, IL				4
5	Frances House, Inc.	100%	Seymour Terrace	North Chicago, IL				5
6	Frances House, Inc.	100%	Waukegan Terrace	Waukegan, IL				6
7	Frances House, Inc.	100%	Pine Terrace	Waukegan, IL				7
8	Pioneer Concepts, Inc.	100%	Broadway Terrace	Chicago Heights, IL	Woodgate	Matteson	CILA	8
9	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL	Thornton	Thornton	CILA	9
10	Pioneer Concepts, Inc.	100%	Flossmoor Terrace	Flossmoor, IL				10
11	Pioneer Concepts, Inc.	100%	Ravisloe Terrace	Country Club Hills, IL				11
12	Pioneer Concepts, Inc.	100%	Spaulding Terrace	Markham, IL				12
13	Pioneer Concepts, Inc.	100%	Calumet City Terrace	Calumet City, IL				13
14	Pioneer Concepts, Inc.	100%	Dolton Terrace	Dolton, IL				14
15	Pioneer Concepts, Inc.	100%	Lynwood Terrace	Lynwood, IL				15
16	Pioneer Concepts, Inc.	100%	Holland Terrace	South Holland, IL				16
17	Pioneer Concepts, Inc.	100%	Matteson Court	Matteson, IL				17
18	Pioneer Concepts, Inc.	100%	Priarie House	Sauk Village, IL				18
19	Pioneer Concepts, Inc.	100%	Torrence Place	Sauk Village, IL				19
20	Pinnacle Opportunities	100%	Chambness Square	Bourbannais, IL	Gravlin Square	Bradley, IL	CILA	20
21	Pinnacle Opportunities	100%	Collins Square	Bradley, IL				21
22	Pinnacle Opportunities	100%	Dearborn Court	Kankakee, IL				22
23	Pinnacle Opportunities	100%	River Court	Kankakee, IL				23
24	Pinnacle Opportunities	100%	Station Court	Kankakee, IL				24
25	Pinnacle Opportunities	100%	Eagle Court	Kankakee, IL				25
26	Pinnacle Opportunities	100%	Kankakee Court	Kankakee, IL				26
27	Pinnacle Opportunities	100%	Roy Court	Bourbannais, IL				27
28	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	See Attached Schedule 7A								\$ 1,091	L18, C7	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	\$ 1,091		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seborg Terrace # 0033936 Report Period Beginning: 4/1/2024 Ending: 3/31/2025

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 Frances House, Inc.
Street Address 285 S. Farnham
City / State / Zip Code Galesburg, IL 61401
Phone Number (309) 343-1550
Fax Number (309) 343-2857

	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	18	Director Fees	Bed Days Avail-FH only	3,168	17	\$ 18,000	\$	192	\$ 1,091	1
2	19	Professional Services	Bed Days Avail-FH only	3,168	17	16,538		192	1,002	2
3	26	Property Insurance	Bed Days Avail-FH only	3,168	17	13,968		192	847	3
4	20	Dues, Fees & Subscriptions	Bed Days Available	5,916	33	279		192	9	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					\$ 48,785	\$		\$ 2,949	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

** 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.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$	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.				\$	7
Assessed Value from Real Estate Tax Bill:	2024	N/A	8		
Real Estate Tax Bill for Calendar Year:	2020	N/A	9		
	2021	N/A	10		
	2022	N/A	11		
	2023	N/A	12		
	2024	N/A	13		
The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

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

FACILITY NAME Seborg Terrace COUNTY Winnebago
FACILITY IDPH LICENSE NUMBER 0033936
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

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

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

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

4,002

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1
- C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F.

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

N/A
- G.

Have you properly capitalized all major repairs and equipment purchases?

Yes
- H.

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- I.

Are you presently operating under a sublease agreement?

No
- J.

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

YES

NO

X

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

N/A

- K.

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

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	49,200		1990		\$ 22,692	
2							
3	TOTALS	49,200				\$ 22,692	

SEE ACCOUNTANTS' PREPARATION REPORT

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	16		1990	1988	\$ 442,308	\$	30	\$	\$	442,308
5										
6										
7										
8										
	Improvement Type**									
9	Water Heater			1997			10			
10	Bathroom and Kitchen Remodeling, Vinyl flooring			2001			5-15 yrs			
11	Siding and Gutters			2002			15			
12	Carpeting			2003			5			
13	Wallcovering, Roofing			2004			5-10 yrs			
14	Roof, Bath/Shower			2005			7-10 yrs			
15	Carpet, Vinyl			2009	12,700		8			12,700
16	New Furnace			2016	6,700	447	15	447		4,131
17	New Closet doors and closet shelving			2016	2,918	194	15	194		1,783
18	Bathroom 1 Remodel-Vanity/Cabinet/Tile/Fixtures/Bath/Toilet			2017	16,069	1,339	12	1,339		10,824
19	Bathroom 2 Remodel-Tile/Vanity/Fixtures/Cabinets/Bath/Toilet			2017	16,069	1,339	12	1,339		10,824
20	New Vinyl Tile - Resident Rooms			2018	22,008	2,200	10	2,200		15,221
21	Interior Painting - Wall/Ceilings - Entire Facility			2019	11,400	190	5	190		11,400
22	Convert Sprinkler System to a Wet System			2019	14,700	1,225	12	1,225		6,227
23	Convert Sprinkler System to a Wet System			2021	4,800	320	15	320		1,360
24	New Asphalt Parking Lot			2022	29,247	3,656	8	3,656		9,444
25	Install New Roof - Entire Facility			2025	24,070	201	10	201		201
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

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)		\$602,989	\$11,111		\$11,111	\$	\$526,423	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$68,488	\$4,063	\$3,686	\$(377)	3-15 yrs	\$37,556	71
72	Current Year Purchases	9,481	617	617		12-15 yrs	617	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$77,969	\$4,680	\$4,303	\$(377)		\$38,173	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care - Wheelchair	2002 E350 Ford Van	2002	\$21,849	\$	\$	\$	4	\$21,849	76
77										77
78										78
79										79
80	TOTALS			\$21,849	\$	\$	\$		\$21,849	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)	\$725,499	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,791	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$15,414	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(377)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$586,445	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	Van 1993	\$5,918	\$	\$5,918	86
87					87
88					88
89					89
90					90
91	TOTALS	\$5,918	\$	\$5,918	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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- Facility Owned
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: N/A
- *

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: \$ N/A
- 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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ 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

☒

☐

☐

138

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)		10,218		10,218
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 10,218	\$	\$ 10,218
10	SUM OF line 9, col. 1 and 2 (e)	\$ 10,218			

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(29,565)	(29,565)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	4,856,024	4,856,024	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,826,459	\$ 4,826,459	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	650,186	602,989	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	107,619	99,818	16
17	Accumulated Depreciation (book methods)	(638,801)	(586,445)	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):	2,661	2,661	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 131,665	\$ 141,715	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,958,124	\$ 4,968,174	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,311	9,311	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,311	\$ 9,311	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,311	\$ 9,311	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,948,813	\$ 4,958,863	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,958,124	\$ 4,968,174	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,933,606	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,933,606	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	15,207	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 15,207	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)	\$ 4,948,813	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Seborg Terrace

0033936

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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	\$ 889,719	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 889,719	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	10,218	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)	\$ 10,218	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			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)	\$ 899,937	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	198,065	31
32	Health Care	393,927	32
33	General Administration	210,831	33
	B. Capital Expense		
34	Ownership	15,791	34
	C. Ancillary Expense		
35	Special Cost Centers	8,183	35
36	Provider Participation Fee	57,933	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 884,730	40
41	Income before Income Taxes (line 30 minus line 40)**	15,207	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 15,207	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 889,719.00	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		48
49	Medicare Part A		49
50	Other-(specify)		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)	\$ 889,719	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	121	127	4,293	33.80	3
4	Licensed Practical Nurses	171	180	5,188	28.82	4
5	CNAs & Orderlies	16,796	18,127	347,821	19.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,451	1,823	38,471	21.10	15
16	Dishwashers					16
17	Maintenance Workers	641	687	17,366	25.28	17
18	Housekeepers	1,180	1,243	22,677	18.24	18
19	Laundry					19
20	Administrator	241	265	9,499	35.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,115	1,199	28,901	24.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	380	400	8,159	20.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,096	24,051	\$ 482,375 *	\$ 20.06	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	\$ 2,417	L1, C3	35
36	Medical Director	Monthly	1,071	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	711	L10, C3	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) Dental	Monthly	6,528	L10, C3	46
47	Psychological Consultant	Monthly	4,805	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,532		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Antoinette Harvey	Administrator	None	\$ 9,499
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 9,499
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
RFMS, Inc.	Administrative Services	\$	35,688
LTC Support Services, LLC	Support Services		25,620
RSM US LLP	Accounting Services		2,970
Templin Healthcare Accounting	Accounting Services		1,669
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	65,947
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	11,446
Unemployment Compensation Insurance			
FICA Taxes			36,102
Employee Health Insurance			24,169
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)* 401k			2,072
Other Employee Benefits			1,956
TOTAL (agree to Schedule V, line 22, col.8)		\$	75,745
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			4,169
Health Care Worker Background Check (Indicate # of checks performed 23)			27
Patient Background Checks			9
Association Dues (total from pg 22, #4)			669
Subscriptions			1,244
Indirect costs			9
Less: Public Relations Expense		(	
PAC and Lobbying payments			(224)
All non-allowable advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)		\$	5,894
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			561
Seminar Expense			
Entertainment Expense		(	
TOTAL (agree to Sch. V, line 24, col. 8)		\$	561

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****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

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

445

445

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.

IL HEALTHCARE ASSOCIATION (IHCA)

224

224

Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)

669

669

Total
- (5)

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

\$ 3,378

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.

\$ 57,933

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.

\$ N/A

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

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

\$ N/A
- (13)

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

Yes

Firm Name: RSM US LLP
- (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.

N/A

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