

		FOR BHF USE						

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0023275</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Sheltered Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>600 Borden Street</u> <u>Woodstock</u> <u>60098</u> Number City Zip Code			
County: <u>McHenry</u>			
Telephone Number: <u>8153386440</u> Fax # <u>8153386803</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>01/01/1977</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Lauren Schlendorf</u> (Title) <u>Admistrator</u>	
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____		(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____	
☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact Name: <u>Robert Keeler</u> Telephone Number: <u>##</u>			
Email Address: _____			

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberDorr-Wood LTD dba Sheltered Village#23275Report Period Beginning:1/1/2025Ending:#####

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

1234

Beds at Beginning of Report Period

Licensure Level of Care

Beds at End of Report Period

Licensed Bed Days During Report Period

1234567

Skilled (SNF)

Skilled Pediatric (SNF/PED)

Intermediate (ICF)

Intermediate/DD

Sheltered Care (SC)

ICF/DD 16 or Less

TOTALS

969635,040

1234567

B. Census-For the entire report period.

123456789

Level of Care

Medicaid Fee for Service

Medicaid MLTSS

MMAI

Medicaid Primary

Medicare Primary

Private Pay

Medicare Part A Only

Other

Total

891011121314

SNF

SNF/PED

ICF

ICF/DD

SC

DD 16 OR LESS

TOTALS

30,001

660

30,661

30,00166030,661

891011121314

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

87.50%

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

0

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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?

YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YESNOX

I. On what date did you start providing long term care at this location?

Date started01/01/1977

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

YESDateNONOX

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

YESNONOX

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUALXMODIFIEDCASH*CASH*

Is your fiscal year identical to your tax year?

YESXNONO

Tax Year:DecFiscal Year:Dec

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

	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	327,105	47,634	10,404	385,143		385,143		385,143		1
2	Food Purchase		327,280		327,280		327,280	(2,715)	324,565		2
3	Housekeeping	259,300	19,942		279,242		279,242		279,242		3
4	Laundry			4,215	4,215		4,215		4,215		4
5	Heat and Other Utilities			123,085	123,085		123,085		123,085		5
6	Maintenance	62,562	42,217	68,207	172,986		172,986		172,986		6
7	Other (specify):*										7
8	TOTAL General Services	648,967	437,073	205,911	1,291,951		1,291,951	(2,715)	1,289,236		8
	B. Health Care and Programs										
9	Medical Director			48,000	48,000		48,000		48,000		9
10	Nursing and Medical Records	2,642,472	160,455	123,830	2,926,757	(8,724)	2,918,033		2,918,033		10
10a	Therapy										10a
11	Activities	366,938	4,254	128	371,320		371,320		371,320		11
12	Social Services	400,166	258	30,075	430,499		430,499		430,499		12
13	CNA Training	4,362			4,362	8,878	13,240		13,240		13
14	Program Transportation			33,894	33,894		33,894		33,894		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,413,938	164,967	235,927	3,814,832	154	3,814,986		3,814,986		16
	C. General Administration										
17	Administrative	290,499		12,526	303,025		303,025		303,025		17
18	Directors Fees										18
19	Professional Services			46,501	46,501		46,501		46,501		19
20	Dues, Fees, Subscriptions & Promotions			17,326	17,326		17,326		17,326		20
21	Clerical & General Office Expenses	124,674	22,093	27,922	174,689	(154)	174,535		174,535		21
22	Employee Benefits & Payroll Taxes			955,485	955,485		955,485		955,485		22
23	Inservic Training & Education										23
24	Travel and Seminar			9,886	9,886		9,886		9,886		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			239,493	239,493		239,493		239,493		26
27	Other (specify):*			(1)	(1)		(1)		(1)		27
28	TOTAL General Administration	415,173	22,093	1,309,138	1,746,404	(154)	1,746,250		1,746,250		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,478,078	624,133	1,750,976	6,853,187		6,853,187	(2,715)	6,850,472		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			105,063	105,063		105,063	116,500	221,563		30
31	Amortization of Pre-Op. & Org.							1,296	1,296		31
32	Interest			1,296	1,296		1,296	(1,296)			32
33	Real Estate Taxes			83,664	83,664		83,664		83,664		33
34	Rent-Facility & Grounds			250,000	250,000		250,000	(250,000)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			440,023	440,023		440,023	(133,500)	306,523		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			404,142	404,142		404,142		404,142		42
43	Other (specify):* Day Training	494,911	7,911	250,710	753,532		753,532	(753,532)			43
44	TOTAL Special Cost Centers	494,911	7,911	654,852	1,157,674		1,157,674	(753,532)	404,142		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,972,989	632,044	2,845,851	8,450,884		8,450,884	(889,747)	7,561,137		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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	1,296	31		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	2,715	2		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				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 Day Training	753,532	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 757,543		\$	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	2	
		Amount	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)	133,500	Shed	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 133,500		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 891,043		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	2	3	4	
		Yes	No	Amount	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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sheltered Village

ID# 0023275

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		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
Forest Steel Company	100%					
Robert Bowman II and Amy McCue-Swan control 100% of Forest Steel Company						

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 250,000	600 Borden St. LLC	100.00%	\$	\$(250,000)	1
2	V	30	Depreciation				116,500	116,500	2
3	V								3
4	V				Owned by Robert Bowman II and Amy McCue-Swan				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			\$ 250,000			\$ 116,500	\$ * (133,500)	14

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

VII. RELATED PARTIES (continued)

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

☐

YES

☐

NO

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

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

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

Report Period Beginning:

Ending:

ID#

0023275

01/01/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

				Place of Residence	Operator/Licensee	Building Co.	Management	
	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Co./Home Office Ownership Percentage
1	Robert		Bowman	Aurora	IL	50.00000	50.00000	1
2	Amy		McCue-Swan	St. Charles	IL	50.00000	50.00000	2
3								3
4								4
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74								74
75								75

Sheltered Village

Report Period Beginning: ID# 0023275

Ending: 01/01/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

			Place of Residence		Operator/Licensee	Building Co.	Management	
	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Co./Home Office Ownership Percentage
76								76
77								77
78								78
79								79
80								80
81								81
82								82
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144								144
145								145
146								146
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148								148
149								149
150								150

VII. RELATED PARTIES

A. (Continued)

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	None	None	None	None	None	None	None	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Amy McCue-Swan	Secretary and Director		**	0				\$		1
2		Speech Therapist				20	50.00	Wage	42,000	12-1	2
3											3
4	Robert Keeler	Treasurer	Accounting	0.00	0	12	35.00	Wage	29,000	17-1	4
5											5
6	Jay Montgomery	Director	Admin Consultant	0.00	0	5	12.00	Fee	12,000	17-3	6
7											7
8											8
9											9
10	** owns 50% of Forest Steel- Which owns 10% of Dorr-Wood LTD										10
11											11
12											12
13								TOTAL	\$ 83,000		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.

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 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 (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.		\$	80,195	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.)		\$	79,544	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(651)	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	84,315	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	83,664	7	
Assessed Value from Real Estate Tax Bill:	2024	863,336	8		
Real Estate Tax Bill for Calendar Year:	2020	65,542	9		
	2021	68,062	10		
	2022	71,437	11		
	2023	76,375	12		
	2024	79,544	13		
12/31/25 Accrual 79544 @ 1.06%= 84315					

FOR BHF USE ONLY		
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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheltered Village COUNTY McHenry
FACILITY IDPH LICENSE NUMBER 0023275
CONTACT PERSON REGARDING THIS REPORT Robert Keeler
TELEPHONE 8157512080 FAX #: 8153386803

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>13-06-306-006</u>	<u>600 Borden St. Woodstock, IL</u>	\$ <u>79,544.00</u>	\$ <u>79,544.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>79,544.00</u>	\$ <u>79,544.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

Yes

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

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

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

YES

NO

X

If YES, please indicate name of the facility.

IDPH license number of this related party and the date the present owners took over.

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	4.9 Acre	2024	\$ 500,000	1
2					2
3	TOTALS	#VALUE!		\$ 500,000	3

XL 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	96		2024		\$ 4,660,000	\$	39	\$ 116,500	\$ 116,500	\$ 289,563	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalk & Pad		2000		3,851					3,851	9
10	90 x 40 Building Addition		2003		629,115	16,131	39	16,131		358,246	10
11	Shower Remodel		2004		27,050	694	39	694		15,057	11
12	Blacktop Walkout		2006		11,675		15			11,675	12
13	Door Project		2006		11,614	290	39	290		5,650	13
14	Attic Firewalls		2011		9,743	244	39	244		3,542	14
15	Roof Work Replace Shingles		2011		18,691	467	39	467		6,639	15
16	Widen Resident doors		2013		7,580	189	39	189		2,320	16
17	Roof Work- Replace Shingles		2014		13,100	774	15	774		10,393	17
18	New Side Entry Door		2016		9,250	231	39	231		2,281	18
19	Fence Door		2018		2,251	150	39	150		1,125	19
20	Seal Coat parking lot		2018		2,643	176	15	176		1,321	20
21	sidewalk blacktop		2019		4,500	300	15	300		1,950	21
22	Windows- Resident rooms		2020		38,000	950	39	950		4,790	22
23	Courtyard concrete work		2020		4,000	267	15	267		1,367	23
24	Office windows		2020		4,140	104	39	104		522	24
25	new garage		2021		36,300	908	39	908		4,273	25
26	rehab old garage		2021		16,340	409	39	409		1,923	26
27	Dining room windows		2021		4,400	110	39	110		527	27
28	blacktop & sealcoat parking lot		2022		10,043	670	15	670		2,343	28
29	tile flooring		2023		33,272	832	39	832		2,322	29
30	courtyard sidewalk		2023		5,850	390	15	390		975	30
31	activity room flooring		2023		2,714	68	39	68		172	31
32	steel door maintenance area		2023		14,272	357	39	357		788	32
33	automatic door to courtyard		2023		6,950	174	39	174		369	33
34	livingroom camera		2024		1,900	127	15	127		190	34
35	carpet activity room floor sound proofing		2024		3,462	231	15	231		346	35
36	handrails- for resident safety		2025		7,190	240	15	240		240	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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	blacktop parking lot	2025	\$ 35,940	\$ 1,198	15	\$ 1,198		\$ 1,198	37
38	Remodel Special Care rooms	2025	5,542	185	15	185		185	38
39	Rounded			(4)		(4)			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)		\$ 5,641,280	\$ 26,862		\$ 143,362	\$ 116,500	\$ 736,143	70

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

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	\$250,665	\$43,748	\$43,748	\$	7-May	\$125,200	71
72	Current Year Purchases	27,680	2,037	2,037		7-May	2,037	72
73	Fully Depreciated Assets	357,206				7-May	357,206	73
74								74
75	TOTALS	\$585,551	\$45,785	\$45,785	\$		\$484,443	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	Resident Transport	2018 Honda Van	2025	\$32,229	\$3,223	\$3,223	\$	5	\$3,223	76
77	Resident Transport	2018 Starcraft Van	2024	94,019	18,803	18,803		5	28,206	77
78	Resident Transport	2019 Pacifica Van	2020	37,432	6,551	6,551		5	37,432	78
79	Resident Transport	Other vehicles	Varies	77,955	3,839	3,839		5	77,955	79
80	TOTALS			\$241,635	\$32,416	\$32,416	\$		\$146,816	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)	\$6,968,466	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$105,063	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$221,563	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$116,500	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,365,402	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	DT Assets	\$191,277	\$14,785	\$170,577	86
87					87
88					88
89					89
90					90
91	TOTALS	\$191,277	\$14,785	\$170,577	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:	1969	96	01/01/91	\$ 250,000			3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$ 250,000			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 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:
- Beginning02/01/2024
- Ending

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2026	\$ 250,000
13.	12/31/2027	\$ 250,000
14.	12/31/2028	\$ 250,000

* 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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

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)				154		154
4	Clinical Wages (b)				4,362		4,362
5	In-House Trainer Wages (c)				8,724		8,724
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$		\$	13,240	\$	\$ 13,240
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,240				

- (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 ir your facility. Drop-out costs can only be for costs incurred by your own CNAs

C. CONTRACTUAL INCOME

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

\$ zero

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	6
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5		6	7	8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
							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 prescripts									9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs									
10	Academic Education			hrs									10
11	Other (specify):												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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$277,814	\$	1
2	Cash-Patient Deposits	133,645		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,766		3
4	Supply Inventory (priced at cost)	10,788		4
5	Short-Term Investments			5
6	Prepaid Insurance	123,203		6
7	Other Prepaid Expenses	7,767		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,141,983	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	981,378		15
16	Equipment, at Historical Cost	877,186		16
17	Accumulated Depreciation (book methods)	1,077,840		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Day Training Assets	20,700		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$801,424	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,943,407	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$233,315	\$	26
27	Officer's Accounts Payable	9,346		27
28	Accounts Payable-Patient Deposits	133,645		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,216		30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,315		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)	\$606,837	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	61,291		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)	\$61,291	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$668,128	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$1,275,279	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,943,407	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,275,340	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,275,340	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	293,938	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	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Rounding	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (6,061)	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)	\$ 1,269,279	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,682,423	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,682,423	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	23,520	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,520	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,658	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,658	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Income	2,041,689	28
28a	Commissary- Net	10,376	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,052,065	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,766,666	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,291,951	31
32	Health Care	3,814,832	32
33	General Administration	1,746,404	33
B. Capital Expense			
34	Ownership	440,023	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	404,142	36
D. Other Expenses (specify):			
37	Day Training Program	753,532	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,450,884	40
41	Income before Income Taxes (line 30 minus line 40)**	315,782	41
42	Income Taxes	21,844	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 293,938	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 5,420,886.00	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	121,535.00	48
49	Medicare Part A		49
50	Other-(specify) Social Security	1,140,002.00	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)	\$ 6,682,423	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,080	\$ 116,012	\$ 55.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,500	15,448	755,437	48.90	3
4	Licensed Practical Nurses	9,101	9,784	410,350	41.94	4
5	CNAs & Orderlies					5
6	CNA Trainees	290	290	4,362	15.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,676	2,802	93,118	33.23	9
10	Activity Assistants	13,502	14,081	271,294	19.27	10
11	Social Service Workers	1,791	2,101	63,448	30.20	11
12	Dietician					12
13	Food Service Supervisor	2,582	2,784	91,236	32.77	13
14	Head Cook	1,848	1,996	46,891	23.49	14
15	Cook Helpers/Assistants	3,257	3,497	72,977	20.87	15
16	Dishwashers	6,308	6,591	118,745	18.02	16
17	Maintenance Workers	6,827	7,349	187,029	25.45	17
18	Housekeepers	5,755	6,243	122,651	19.65	18
19	Laundry	1,178	1,268	24,274	19.14	19
20	Administrator	1,960	2,080	159,000	76.44	20
21	Assistant Administrator					21
22	Other Administrative	1,040	2,080	102,499	49.28	22
23	Office Manager	1,922	2,133	53,779	25.21	23
24	Clerical	1,898	2,073	101,583	49.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	9,451	10,143	327,039	32.24	28
29	Resident Services Coordinator	2,040	2,080	97,402	46.83	29
30	Habilitation Aides (DD Homes)	43,228	50,495	1,208,158	23.93	30
31	Medical Records	1,922	2,082	50,794	24.40	31
32	Other Health Care(specify)					32
33	Other(specify)	18,658	20,687	494,911	23.92	33
34	TOTAL (lines 1 - 33)	153,774	170,167	\$ 4,972,989 *	\$ 29.22	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	144	\$ 6,600		35
36	Medical Director	208	48,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	65	10,078		39
40	Physical Therapy Consultant	112	2,493		40
41	Occupational Therapy Consultant	14	1,068		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	1,425		43
44	Activity Consultant				44
45	Social Service Consultant	8	560		45
46	Other(specify)	22	4,398		46
47	Behavior Consultant	416	27,592		47
48					48
49	TOTAL (lines 35 - 48)	1,008	\$ 102,214		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	10	319	10-3	51
52	Certified Nurse Assistants/Aides	41	770	10-3	52
53	TOTAL (lines 50 - 52)	51	\$ 1,089		53

Facility Name & ID Number Sheltered Village		STATE OF ILLINOIS	Page 22
# 0023275		Report Period Beginning: 01/01/2025	Ending: 12/31/2025

(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 expend
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.

\$ 404,142

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'

N/A

(10)

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

No

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

(11)

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

\$ Has any meal income been offset against
related costs?

Indicate the amount. \$

(12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

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

100%

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

\$

(13)

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

Firm Name:

No

(14)

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

Yes

(15)

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

See page 39 of the instructions for details.

Yes

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