

		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: 0054999

Facility Name: Springs at Monarch Landing

Address: 2309 N Route 59 Naperville 60563
Number City Zip Code

County: Dupage

Telephone Number: 630-330-1181 Fax # 630-300-1386

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1980

Type of Ownership:

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

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

In the event there are further questions about this report, please contact:
Name: Rob Schlicht Telephone Number: 414-431-9335
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Elizabeth Vanderwal
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Rob Schlicht Director
(Firm Name & Address) Wipfli Advisory LLC 10000 Innovation Drive, Suite 250, Milwaukee, WI 53226
(Telephone) 414-431-9335 Fax # 414-431-9303

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

Facility Name & ID Number Springs at Monarch Landing # 0054999 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	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	1,802				21,613		9,317	32,732	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,802				21,613		9,317	32,732	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.41%

D. How many bed reserve days during this year were paid by the Department? None (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)

Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 10/19/2014

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 96

Medicare Intermediary National Government Services (Anthem)

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Springs at Monarch Landing # 0054999 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	497,604	46,881	6,421	550,906		550,906	(248)	550,658			1
2	Food Purchase		432,518		432,518		432,518		432,518			2
3	Housekeeping	291,455	49,986	3,660	345,101		345,101	(190)	344,911			3
4	Laundry			133,650	133,650		133,650		133,650			4
5	Heat and Other Utilities			1,276,693	1,276,693		1,276,693		1,276,693			5
6	Maintenance	113,369	3,180	308,193	424,742		424,742	(73,056)	351,686			6
7	Other (specify):*			(200,556)	(200,556)		(200,556)		(200,556)			7
8	TOTAL General Services	902,428	532,565	1,528,061	2,963,054		2,963,054	(73,494)	2,889,560			8
	B. Health Care and Programs											
9	Medical Director			26,902	26,902		26,902		26,902			9
10	Nursing and Medical Records	6,565,818	18,943	818,785	7,403,546		7,403,546		7,403,546			10
10a	Therapy	878,307		199	878,506		878,506		878,506			10a
11	Activities	175,414	70	8,341	183,825		183,825		183,825			11
12	Social Services	174,962			174,962		174,962		174,962			12
13	CNA Training	52,526			52,526		52,526		52,526			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,847,027	19,013	854,227	8,720,267		8,720,267		8,720,267			16
	C. General Administration											
17	Administrative	75,400	6,533	13,008	94,941		94,941	(7,241)	87,700			17
18	Directors Fees											18
19	Professional Services			1,487	1,487		1,487		1,487			19
20	Dues, Fees, Subscriptions & Promotions			76,065	76,065		76,065	(47,146)	28,919			20
21	Clerical & General Office Expenses	233,440		42,972	276,412		276,412	(37,890)	238,522			21
22	Employee Benefits & Payroll Taxes			2,030,267	2,030,267		2,030,267		2,030,267			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,686	4,686		4,686	(4,630)	56			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	308,840	6,533	2,168,485	2,483,858		2,483,858	(96,907)	2,386,951			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,058,295	558,111	4,550,773	14,167,179		14,167,179	(170,401)	13,996,778			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,755,215	4,755,215		4,755,215	(540)	4,754,675			30
31	Amortization of Pre-Op. & Org.			737,871	737,871		737,871		737,871			31
32	Interest			1,884,704	1,884,704		1,884,704		1,884,704			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,327	1,327		1,327		1,327			35
36	Other (specify):*											36
37	TOTAL Ownership			7,379,117	7,379,117		7,379,117	(540)	7,378,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			559,045	559,045		559,045		559,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			290,866	290,866		290,866		290,866			42
43	Other (specify):*	7,658,184	556,091	13,037,170	21,251,445		21,251,445		21,251,445			43
44	TOTAL Special Cost Centers	7,658,184	556,091	13,887,081	22,101,356		22,101,356		22,101,356			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	16,716,479	1,114,202	25,816,971	43,647,652		43,647,652	(170,941)	43,476,711			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	179	32		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	(292,064)	32		14
15	Non-Care Related Owner's Transactions	(4,519,993)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(170,941)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,982,819)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (4,982,819)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Housekeeping Revenue	(190)	3	3
4	Transportation Revenue	(37,890)	21	4
5	Cable TV	(73,056)	6	5
6	Storage Unit	(540)	30	6
7	Travel - Airlines/Hotel/Car Rental (Skilled Nursing - SN	(4,630)	24	7
8	Promo and Sales - Site Events -Leads & Prospect/Adult t	(47,146)	20	8
9	Contributions (SNF - G & A)	(7,241)	17	9
10	Guest Meals Income	(248)	1	10
11				11
12				12
13				13
14				14
15				15
16				16
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(170,941)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Senior Living Operators (SL-VII), LLC	100					

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

STATE OF ILLINOIS

Ownership Listing-2

Springs at Monarch Landing

ID# 0054999

Report Period Beginning: 01/01/2025

Ending: 12/31/202

-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.

Operator/Licensee

Building Co.	Co. /Home Office
1	
2	
3	
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Ownership	Ownership
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	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
76								76
77								77
78								78
79								79
80								80
81								81
82								82
83								83
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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 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 2/31/2025

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

Facility Name & ID Number Springs at Monarch Landing # 0054999 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

()

()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

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.)				\$28,388	2
3. Under or (over) accrual (line 2 minus line 1).				\$28,388	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.				\$28,388	7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 1,105,088 9					
2021 1,091,091 10					
2022 1,089,332 11					
2023 1,208,977 12					
2024 59,803 13					
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Springs at Monarch Landing COUNTY Dupage
FACILITY IDPH LICENSE NUMBER 0054999
CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler
TELEPHONE 847-374-0400 FAX #: 847-374-0420

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: 45,443 B. General Construction Type: Exterior Frame Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Independent Living 364 Units
Assisted Living 28 Units
Adult Day Care

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Land	45,443		2018		\$ 479,820	
2							
3	TOTALS	45,443				\$ 479,820	

Facility Name & ID Number Springs at Monarch Landing

0054999

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96		2018	2014	\$ 5,844,706	\$ 152,035	25 to 40	\$ 152,035	\$	\$ 1,087,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements (see detailed subschedule			2018	187,565	9,702		9,702		71,738	9
10	Improvements (see detailed subschedule			2019	108,491	5,042		5,042		60,536	10
11	Improvements (see detailed subschedule			2020	27,472	1,752		1,752		9,516	11
12	Improvements (see detailed subschedule			2021	50,618	3,210		3,210		13,885	12
13	Improvements (see detailed subschedule			2022	74,880	4,961		4,961		17,518	13
14	Improvements (see detailed subschedule			2023	103,434	6,796		6,796		16,490	14
15	Improvements (see detailed subschedule			2024	176,654	11,768		11,768		16,510	15
16	Improvements (see detailed subschedule			2025	113,904	2,637		2,637		2,637	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,687,724	\$ 197,903		\$ 197,903	\$	\$ 1,296,049	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 437,037	\$ 37,130	\$ 37,130	\$	10	\$ 251,554	71
72	Current Year Purchases					3-10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 437,037	\$ 37,130	\$ 37,130	\$		\$ 251,554	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		1149140-Vehicles - Opening	2018	\$ 21,519	\$	\$	\$	5	\$ 21,519	76
77		2201493-2026 Honda CRV	2025	42,319	705	705		5	705	77
78		2201494-2025 Honda Accord	2025	36,477	608	608		5	608	78
79		1978991-F350 Engine	2024	12,431	207	207		5	3,315	79
80	TOTALS			\$ 112,746	\$ 1,520	\$ 1,520	\$		\$ 26,147	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)	\$ 7,717,327	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,553	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,553	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,573,750	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	\$ 112,311,493	\$ 2,921,503	\$ 20,891,929	86
87	Equipment	8,398,056	713,468	4,833,872	87
88	Vehicle	107,169	3,612	24,854	88
89	Improvements - Building and Land	16,147,948	881,410	4,012,892	89
90	Land	9,220,180			90
91	TOTALS	\$ 146,184,846	\$ 4,519,993	\$ 29,763,547	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?YESNO
- If NO, see instructions.

		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:YESNO

Terms:

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

15. Is Movable equipment rental included in building rental?YESNO
16. Rental Amount for movable equipment: \$

Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-1	hrs	\$ 279,146		\$	\$		\$ 279,146	1
2	Licensed Speech and Language Development Therapist	10a-1	hrs	90,593					90,593	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-1	hrs	508,568					508,568	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			\$ 878,307		\$	\$		\$ 878,307	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	\$ 10,777,911	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,145,079		3
4	Supply Inventory (priced at)	104,842		4
5	Short-Term Investments			5
6	Prepaid Insurance	576,827		6
7	Other Prepaid Expenses	35,454		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	220,291		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 16,860,404	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,700,000		13
14	Buildings, at Historical Cost	118,156,199		14
15	Leasehold Improvements, at Historical Cost	16,988,288		15
16	Equipment, at Historical Cost	8,947,839		16
17	Accumulated Depreciation (book methods)	(31,312,443)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,826,306		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,894,298)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	94,201		22
23	Other(specify):	164,127		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 124,670,219	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 141,530,623	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,413,238	\$	26
27	Officer's Accounts Payable	350,795		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	738,568		29
30	Accrued Salaries Payable	1,162,634		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	352,894		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Derivative Instrument /Wait list & Deposit	75,000		36
37	Accrued Expenses	1,062,373		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,155,502	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,006,120		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Attrition	140,031,005		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 166,037,125	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 171,192,627	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (29,662,004)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 141,530,623	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (26,238,697)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (26,238,697)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,423,307)	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)	\$ (3,423,307)	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)	\$ (29,662,004)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Springs at Monarch Landing

0054999

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,894,175	1
2	Discounts and Allowances for all Levels	(2,341,824)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,552,351	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,926,350	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,926,350	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	309	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	540	16
17	Sale of Drugs	335,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,581	19
20	Radiology and X-Ray	19,068	20
21	Other Medical Services	365,275	21
22	Laundry	15	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 782,690	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,045	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,045	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent & Assisted Living	22,869,668	28
28a	Other Income	81,241	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,950,909	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 40,224,345	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,963,054	31
32	Health Care	8,720,267	32
33	General Administration	2,483,858	33
	B. Capital Expense		
34	Ownership	7,379,117	34
	C. Ancillary Expense		
35	Special Cost Centers	21,810,490	35
36	Provider Participation Fee	290,866	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 43,647,652	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,423,307)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,423,307)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 392,917.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	9,935,018.00	45
46	MMAI-Medicaid is the Primary Payer	1,438,445.00	46
47	MMAI-Medicare is the Primary Payer	157,705.00	47
48	Private Pay	628,266.00	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)	\$ 12,552,351	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	4,160	4,160	\$ 322,087	\$ 77.42	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	45,397	46,769	2,263,176	48.39	3
4	Licensed Practical Nurses	20,572	21,194	813,883	38.40	4
5	CNAs & Orderlies	107,265	110,507	2,766,368	25.03	5
6	CNA Trainees			52,526		6
7	Licensed Therapist	8,298	8,549	878,307	102.74	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	8,979	9,221	175,414	19.02	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	6,294	6,484	174,962	26.98	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook			0		14
15	Cook Helpers/Assistants	20,207	20,755	497,604	23.98	15
16	Dishwashers			0		16
17	Maintenance Workers	4,269	4,398	113,369	25.78	17
18	Housekeepers	12,596	12,976	291,455	22.46	18
19	Laundry			0		19
20	Administrator			0		20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	24,177	24,636	306,278	12.43	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified ID Prof (QIDP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	5,391	5,554	119,739	21.56	31
32	Other Health Care(specify)	13,689	5,658	283,128	50.04	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	281,294	280,860	\$ 9,058,296 *	\$ 32.25	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		\$ 1,656		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		56,875		38
39	Pharmacist Consultant		13,450		39
40	Physical Therapy Consultant		63,393		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant		690		43
44	Activity Consultant		1,080		44
45	Social Service Consultant		284		45
46	Other(specify)		9,895		46
47	Managed Care Contracting			3-3	47
48	Chart Audit		11,034		48
49	TOTAL (lines 35 - 48)		\$ 158,358		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,871	\$ 65,758	10-3	50
51	Licensed Practical Nurses	5,836	205,161	10-3	51
52	Certified Nurse Assistants/Aides	3,142	110,437	10-3	52
53	TOTAL (lines 50 - 52)	10,848	\$ 381,356		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Beth Vanderwal	Administrator		\$ 75,400	Workers' Compensation Insurance		\$ 114,526	IDPH License Fee	\$	
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		
				FICA Taxes		669,144	Health Care Worker Background Check		
				Employee Health Insurance		951,592	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				FUTA & SUTA		41,649	Marketing	28,494	
				Employee Insurance		32,157	Professional dues	425	
				401k/403b Employer Match		182,064			
				Housing Allowance and Employee Benefits		39,135			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,400				Less: Public Relations Expense	()	
B. Administrative - Other							PAC and Lobbying payments	()	
Description			Amount				All non-allowable advertising	()	
Training (Skilled Nursing - G & A)			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
Wellness Program - Other (G&A O/H - G & A)			767			\$ 2,030,267	\$ 28,919		
Consultants (Skilled Nursing - G & A)			5,000						
Contributions (SNF - G & A)			7,241						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 13,008	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount				Out-of-State Travel	\$	
Cost Report Preparation			\$ 1,487						
							In-State Travel		
							Travel - Airlines/Hotel/Car Rental	56	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,487	TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 56	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

LEADING AGE

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.

LEADING AGE

Total
- (4)

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

LEADING AGE

Total
- (5)

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

\$

Line
- (6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$

290,866

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee?

No

If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to
the Department, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V?

Yes
- (10)

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

No

For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.
- (11)

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

\$

Has any meal income been offset against
related costs?

No

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?

No

d. Have vehicle usage logs been maintained?

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

Yes

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

Yes

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

No

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

\$

N/A

(13)

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

Firm Name:

Beers, Hammerman, Cohen & Berger PC

Yes

(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.