

		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: 0051466

Facility Name: Thomas Herbstritt House

Address: 4003 N Rt 1-17 B260 Momence 60954
Number City Zip Code

County: Kankakee

Telephone Number: (815)472-3700 Fax # (815)472-2160

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2011

Type of Ownership:

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

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

In the event there are further questions about this report, please contact:
Name: Emily Bonvallet Telephone Number: (815)472-3700 x1370
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 07/01/2024 to 06/30/2025 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) Kristen Stockle
(Title) President

Paid Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number

Thomas Herbstritt House

#

0051466

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

III. STATISTICAL DATA

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

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3		Intermediate (ICF)		3
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6	16	ICF/DD 16 or Less	16	5,840
7	16	TOTALS	16	5,840

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9		
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other		Total
				Medicaid Primary	Medicare Primary					
8	SNF								8	
9	SNF/PED								9	
10	ICF								10	
11	ICF/DD								11	
12	SC								12	
13	DD 16 OR LESS	2,833							2,833	
14	TOTALS	2,833							2,833	

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

48.51%

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

87

(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)

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

X

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

YES

NO

X

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

Date started

07/01/2011

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

YES

Date

07/01/2011

NO

X

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

YES

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

06/30/2025

Fiscal Year:

06/30/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	42,272		1,622	43,894		43,894		43,894			1
2	Food Purchase		5,421		5,421		5,421		5,421			2
3	Housekeeping	12,904	5,155		18,059		18,059		18,059			3
4	Laundry											4
5	Heat and Other Utilities			9,917	9,917		9,917		9,917			5
6	Maintenance	16,949		2,341	19,290		19,290		19,290			6
7	Other (specify):*											7
8	TOTAL General Services	72,125	10,576	13,880	96,581		96,581		96,581			8
	B. Health Care and Programs											
9	Medical Director			3,769	3,769		3,769		3,769			9
10	Nursing and Medical Records	57,954	13,480	300	71,734		71,734		71,734			10
10a	Therapy	536,826			536,826		536,826		536,826			10a
11	Activities			3,160	3,160		3,160		3,160			11
12	Social Services			1,252	1,252		1,252		1,252			12
13	CNA Training	9,600			9,600		9,600		9,600			13
14	Program Transportation			6,566	6,566		6,566		6,566			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	604,380	13,480	15,047	632,907		632,907		632,907			16
	C. General Administration											
17	Administrative	48,771		977	49,748		49,748		49,748			17
18	Directors Fees											18
19	Professional Services			7,927	7,927		7,927		7,927			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		5,909		5,909		5,909		5,909			21
22	Employee Benefits & Payroll Taxes			187,700	187,700		187,700		187,700			22
23	Inservice Training & Education			1,541	1,541		1,541		1,541			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,532	27,532		27,532		27,532			26
27	Other (specify):*											27
28	TOTAL General Administration	48,771	5,909	225,677	280,357		280,357		280,357			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	725,276	29,965	254,604	1,009,845		1,009,845		1,009,845			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			13,427	13,427		13,427		13,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,469	10,469		10,469		10,469			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			124,884	124,884		124,884		124,884			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			148,780	148,780		148,780		148,780			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			36,523	36,523		36,523		36,523			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,523	36,523		36,523		36,523			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	725,276	29,965	439,907	1,195,148		1,195,148		1,195,148			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	\$	N/A	\$	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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))	\$		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

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
BD OF DIRECTORS NON-PROFIT ICF/DD 0						

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.

Ownership Listing-1

ID# 0051466

0051466

07/01/202

06/30/202

Management

Operator/Licensee

Ownership

	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
1	Gina		Pfeifer	Burr Ridge	IL	0.00000		1
2	Patrick		Fitzgerald	Palos Heights	IL	0.00000		2
3	David		Doyle	Arlington Heights	IL	0.00000		3
4	Shane		Navratil	Saint John	IN	0.00000		4
5	Brother Alphonsus		Brown	Momence	IL	0.00000		5
6	Richard		Byrne	Momence	IL	0.00000		6
7	Eric		Cavendar	Bourbonnais	IL	0.00000		7
8	Bruce		Fitzpatrick	Sun City West	AZ	0.00000		8
9	Steven		Hoekstra	St Anne	IL	0.00000		9
10	Betty		Lombard	Palos Park	IL	0.00000		10
11	Joan		O'Brien	Homer Glen	IL	0.00000		11
12	Gary		Ryan	Naples	FL	0.00000		12
13	James		Spoon	Momence	IL	0.00000		13
14	James		Sullivan	Naperville	IL	0.00000		14
15	Peter		Jankowski	Momence	IL	0.00000		15
16	Doris		Williamson	The Villages	FL	0.00000		16
17	Thomas		Wroblewski	Bourbonnais	IL	0.00000		17
18								18
19								19
20								20
21								21
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69								69
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72								72
73								73
74								74
75								75

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								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
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Thomas Herbstritt House # 0051466 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Thomas Herbstritt House # 0051466 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	Northern Trust			line of credit	interest	07/01/2011	\$			7.0000	\$ 6,805	1
2	GSM Foundation			line of credit	interest	07/01/2011				3.5000	3,664	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 10,469	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$ 10,469	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.		\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$		2
3. Under or (over) accrual (line 2 minus line 1).				\$	#VALUE!	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.				\$	#VALUE!	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020		9			
	2021		10			
	2022		11			
	2023		12			
	2024		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	Thomas Herbstritt House	COUNTY	Kankakee
---------------	-------------------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

4,750

B. General Construction Type:

Exterior

vinyl

Frame

brick

Number of Stories

1

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).

Thomas Lombard ICF/DD 16 bedsDay Training 108 clientsLeonard CILA 8 beds

Webber CILA 8 bedsBrown CILA 8 bedsWm McAllister CILA 8 beds

Opler CILA 8 bedsColnon/Wild CILA 8 bedsPark CILA 8 beds

Biesemier/Blagrave CILA 8 bedsZurek CILA 8 bedsHelen McAllister CILA 8 bedsHayes CILA 8 beds

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)?

YESNOX

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

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

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Thomas Herbstritt House

0051466

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Connecting Sidewalk Ford & Sons			2002	1,870		5			1,870	9	
10	Hult - Floor tile & base			2003	2,098		5			2,098	10	
11	Sherwood - ligting & wiring			2003	2,093		5			2,093	11	
12	parking lot Martin Asphalt			2003	3,000		5			3,000	12	
13	re-roof Cousin Construction			2007	1,495		5			1,495	13	
14	FE Moran air compressor			2008	1,277		5			1,277	14	
15	Ford handicap concrete			2008	1,230		5			1,230	15	
16	Menards kitchen cabinets			2008	6,072		5			6,072	16	
17	Herbstirtt Cousins generator hookup			2009	705		5			705	17	
18	Herbstritt Sherwood generator			2009	6,950		5			6,950	18	
19	Herbstritt Cousins furnace			2010	9,364		5			9,364	19	
20	Herbstritt Tousignant new door			2010	1,462		5			1,462	20	
21	Herbstirtt G&J Const 2 counter tops			2011	1,860		5			1,860	21	
22	Herbstritt Home Appl - 5 recliners			2011	3,250		5			3,250	22	
23	Herbstritt Home Appl - 2 couches			2011	2,500		5			2,500	23	
24	Herbstritt Rons Plmb back flow			2011	977		5			977	24	
25	Herbstritt Protect Assoc smoke detector			2012	1,544		5			1,544	25	
26	Moran - valve replacement			2012	3,925		5			3,925	26	
27	Ruder - alarm			2013	951		5			951	27	
28	Reliable Ornamental outside railing			2013	1,695		5			1,695	28	
29	St Peter Const - pantry walls			2013	545		5			545	29	
30	St Peter Const - handrail			2014	1,626		5			1,626	30	
31	Ron's Plmb - water softener			2014	3,164		5			3,164	31	
32	Richards - garage siding			2014	735	12	10	12		735	32	
33	St Peter new windows			2014	9,086	303	10	303		9,086	33	
34	USA Fire Prot - sprinkler system			2016	25,996	2,600	10	2,600		23,830	34	
35	Region -Fencing			2016	3,750	375	10	375		3,375	35	
36	Region -Fencing			2016	4,795	480	10	480		4,276	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	Ron's Plmb booster pump & tank	2016	\$ 2,214	\$ 221	10	\$ 221	\$	\$ 1,974	37
38	Fence	2017	600	60	10	60		505	38
39	Bathfitter - Shower	2018	6,492	649	10	649		4,274	39
40	FCA-Replace Bathroom Flooring	2021	1,824	182	10	182		775	40
41	FCA-Replace Bathroom Flooring	2021	968	97	10	97		403	41
42	St. Peter - New Porch Handrails	2022	1,590	159	10	159		570	42
43	St. Peters - New Bathroom Door	2022	1,000	100	10	100		358	43
44	Heartland - New Cabinets in Kitchen	2023	10,042	1,004	10	1,004		1,841	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)		\$ 128,745	\$ 6,242		\$ 6,242	\$	\$ 111,655	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	\$7,669	\$1,534	\$1,534	\$	5	\$5,330	71
72	Current Year Purchases	1,089	73	73		5	73	72
73	Fully Depreciated Assets	21,256	194	194		5	21,256	73
74								74
75	TOTALS	\$30,014	\$1,801	\$1,801	\$		\$26,659	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	Fleet - allocated			\$113,778	\$5,384	\$5,384	\$		\$76,337	76
77										77
78										78
79										79
80	TOTALS			\$113,778	\$5,384	\$5,384	\$		\$76,337	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)	\$272,537	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$13,427	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$13,427	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)	\$214,651	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:	1995	16		\$124,884	2		3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$124,884			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:
Beginning 07/01/2024
Ending 06/30/2027

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

	Fiscal Year Ending	Annual Rent
12.	06/30/2026	\$125,940
13.	06/30/2027	\$127,008
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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER CNA80

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)	3,200			3,200
4	Clinical Wages (b)	6,400			6,400
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 9,600	\$	\$	\$ 9,600
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,600			

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	4
2. From other facilities (f)	17
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

(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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$19,897	\$	1
2	Cash-Patient Deposits	11,642		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	42,008		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,671		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$80,218	\$	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	128,745		15
16	Equipment, at Historical Cost	143,792		16
17	Accumulated Depreciation (book methods)	(214,651)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$57,886	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$138,104	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$313,861	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,642		28
29	Short-Term Notes Payable	96,354		29
30	Accrued Salaries Payable	234,046		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$665,903	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	124,991		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)	\$124,991	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$790,894	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$(652,790)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$138,104	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (279,276)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (279,276)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,514)	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)	\$ (373,514)	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)	\$ (652,790)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Thomas Herbstritt House

0051466

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 634,114	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 634,114	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	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)	\$ 520	23
	D. Non-Operating Revenue		
24	Contributions	187,000	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 187,000	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 821,634	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	96,581	31
32	Health Care	632,907	32
33	General Administration	280,357	33
	B. Capital Expense		
34	Ownership	148,780	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,195,148	40
41	Income before Income Taxes (line 30 minus line 40)**	(373,514)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (373,514)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 634,114.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	980	1,000	41,571	41.57	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	20,822	23,135	485,852	21.00	5
6	CNA Trainees	480	480	9,600	20.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	160	180	5,486	30.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,075	2,150	36,786	17.11	15
16	Dishwashers					16
17	Maintenance Workers	600	650	16,949	26.08	17
18	Housekeepers	620	670	12,904	19.26	18
19	Laundry					19
20	Administrator	140	170	11,705	68.85	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,050	37,066	35.30	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	2,300	2,400	67,357	28.07	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	29,177	31,885	\$ 725,276 *	\$ 22.75	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	54	\$ 1,622	1-3	35
36	Medical Director	54	3,769	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	1,252	12-3	45
46	Other(specify)				46
47	Administrative	122	7,927	19-3	47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 14,870		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.