

		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: 0056655

Facility Name: Thrive of Lake County

Address: 850 E US HWY 45 Mundelein 60060
Number City Zip Code

County: Lake

Telephone Number: (847) 377-7200 Fax # (480) 436-5749

HFS ID Number:

Date of Initial License for Current Owners: 7/20/2020

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: Andrew B. Cutler Telephone Number: (847) 940-3269
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 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____
(Print Name and Title) Andrew B. Cutler
Managing Director, Healthcare
(Firm Name & Address) FGMK, LLC
2801 Lakeside Dr. 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 964-5469

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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2025 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 <u>N/A</u>					
	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>185</u>	Skilled (SNF)	<u>185</u>	<u>67,525</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>185</u>	TOTALS	<u>185</u>	<u>67,525</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	20,993	15,541	2,684	422	7,399	7,056	3,884	57,979	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	20,993	15,541	2,684	422	7,399	7,056	3,884	57,979	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 85.86%

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) None

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

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

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 7/20/2020

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/20/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 185

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2025 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	625,272	106,454	30,546	762,272		762,272		762,272			1
2	Food Purchase		495,891		495,891		495,891		495,891			2
3	Housekeeping	305,066	39,533		344,599		344,599		344,599			3
4	Laundry		17,587		17,587		17,587		17,587			4
5	Heat and Other Utilities			294,835	294,835		294,835		294,835			5
6	Maintenance	133,360		177,787	311,147		311,147		311,147			6
7	Other (specify):*											7
8	TOTAL General Services	1,063,698	659,465	503,168	2,226,331		2,226,331		2,226,331			8
	B. Health Care and Programs											
9	Medical Director			41,500	41,500		41,500		41,500			9
10	Nursing and Medical Records	7,141,007	473,723	27,517	7,642,247		7,642,247		7,642,247			10
10a	Therapy											10a
11	Activities	111,257		27,062	138,319		138,319		138,319			11
12	Social Services	94,481		22,982	117,463		117,463		117,463			12
13	CNA Training			63,201	63,201		63,201		63,201			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,346,745	473,723	182,262	8,002,730		8,002,730		8,002,730			16
	C. General Administration											
17	Administrative	130,978		1,137,827	1,268,805		1,268,805		1,268,805			17
18	Directors Fees											18
19	Professional Services			435,364	435,364		435,364	(93,592)	341,772			19
20	Dues, Fees, Subscriptions & Promotions			76,764	76,764		76,764	(7,727)	69,037			20
21	Clerical & General Office Expenses	378,048		1,852,508	2,230,556		2,230,556	(801,216)	1,429,340			21
22	Employee Benefits & Payroll Taxes			2,044,232	2,044,232		2,044,232		2,044,232			22
23	Inservice Training & Education											23
24	Travel and Seminar			63,897	63,897		63,897		63,897			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			556,259	556,259		556,259	237,646	793,905			26
27	Other (specify):*											27
28	TOTAL General Administration	509,026		6,166,851	6,675,877		6,675,877	(664,889)	6,010,988			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,919,469	1,133,188	6,852,281	16,904,938		16,904,938	(664,889)	16,240,049			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			60,682	60,682		60,682	1,499,587	1,560,269			30
31	Amortization of Pre-Op. & Org.			1,076	1,076		1,076	5,685	6,761			31
32	Interest							1,061,699	1,061,699			32
33	Real Estate Taxes							279,800	279,800			33
34	Rent-Facility & Grounds			2,027,344	2,027,344		2,027,344	(2,027,344)				34
35	Rent-Equipment & Vehicles			13,089	13,089		13,089		13,089			35
36	Other (specify):*											36
37	TOTAL Ownership			2,102,191	2,102,191		2,102,191	819,427	2,921,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	766,727	274,084	183,525	1,224,336		1,224,336		1,224,336			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			916,973	916,973		916,973		916,973			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	766,727	274,084	1,100,498	2,141,309		2,141,309		2,141,309			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,686,196	1,407,272	10,054,970	21,148,438		21,148,438	154,538	21,302,976			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	(641)	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				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	(44,631)	21		18
19	Entertainment	(24,492)	21		19
20	Contributions	(5,302)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(691,195)	21		24
25	Fund Raising, Advertising and Promotional	(57,267)	21		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	(7,727)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (831,255)		\$	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))	\$ (831,255)		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	(7,727)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,727)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 2,027,344	IH KCB Mundelein Owner, LLC		\$	(2,027,344)	1
2	V	33	Real Estate Tax		IH KCB Mundelein Owner, LLC		279,800	279,800	2
3	V	30	Depreciation		IH KCB Mundelein Owner, LLC		1,499,587	1,499,587	3
4	V	31	Amortization		IH KCB Mundelein Owner, LLC		5,685	5,685	4
5	V	32	Interest Expense		IH KCB Mundelein Owner, LLC		1,062,340	1,062,340	5
6	V	26	Insurance		IH KCB Mundelein Owner, LLC		237,646	237,646	6
7	V	21	Professional Fees		IH KCB Mundelein Owner, LLC		21,671	21,671	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,027,344			\$ 3,106,729	\$ * 1,079,385	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	19	Asset Management Fee	\$ 93,592	IH Asset Management		\$	\$ (93,592)	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			\$ 93,592			\$ 0	\$ * (93,592)	39

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

Ownership Listing-1

ID# 0056655

1/1/2025

IH KCB Mundlein Owner

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

Operator/Licensee

Place of Residence

Ownership

Ownership

Percentage

Ownership

Percentage

1	Bradley	S	Haber	Glencoe	IL	6.75000	6.75000	1
2	Brian	J	Cloch	Riverwoods	IL	6.75000	6.75000	2
3	Kurt	C	Read	Dallas	TX	0.75000	0.75000	3
4	Stephanie	S	Read	Dallas	TX	0.75000	0.75000	4
5	David		Weiss	St. Louis	MO	2.50000	2.50000	5
6	Jeff		Cook	St. Louis	MO	2.50000	2.50000	6
7	Harvey		Knell	Pasadena	CA	80.00000	80.00000	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								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								70
71								71
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 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	Thrive of Lisle	Lisle, IL			IH KCB Mundelein		Building Prtshp	1
2	Thrive of Fox Valley	Aurora, IL			Owner, LLC	Mundlein		2
3					IH KCB Fox Valley		Building Prtshp	3
4					Owner, LLC	Auora		4
5					IH KCB Lisle		Building Prtshp	5
6					Owner, LLC	Lisle		6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2025 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	HUD		X	Mortgage			\$	24,082,830			\$	1,062,340	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	24,082,830			\$	1,062,340	9
	B. Non-Facility Related*												
10	Interest Income		X									(641)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(641)	14
15	TOTALS (line 9+line14)						\$	24,082,830			\$	1,061,699	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 189,130 Line # 26

* 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.		\$	287,900	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.)				\$	268,628	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	(19,272)	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	299,072	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.				\$	279,800	7	
Assessed Value from Real Estate Tax Bill:	2024	2,466,980	8				
Real Estate Tax Bill for Calendar Year:	2020	97,445	9				
	2021	154,270	10				
	2022	255,927	11				
	2023	279,565	12				
	2024	268,628	13				
Re Tax Accrual = \$268628*1.1 = \$299,072 Rounded)				16	LESS REFUND FROM LINE 6	\$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$		17

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thrive of Lake County COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0056655

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.	15-06-203-033	Long-Term Care property	\$ 8,707.88	\$ 8,707.88
2.	15-06-203-034	Long-Term Care property	\$ 259,920.94	\$ 259,920.94
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 268,628.82	\$ 268,628.82

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:93,071B. General Construction Type:ExteriorBrick/Stone/SidingFrameWood/SteelNumber of Stories1
- 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).

None

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

- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?☒ YES☐ NO
If so, please complete the following:

1. Total Amount Incurred:38,2542. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:1,0764. Dates Incurred:

Nature of Costs:Organizational Expense
(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	Long-Term Care Property		469,311		2016		\$ 2,275,000	
2								
3	TOTALS		469,311				\$ 2,275,000	

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	185		2020	2020	\$ 29,647,932	\$	27.5	\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Dialysis Unit Construtction, Plumbing, Electrical, infrastructure			2024	178,399		20				9
10	Smoke Alarm Wiring at reception lobby			2024	3,350		20				10
11	Electrical work - Kitchen			2024	1,404		20				11
12				2025	20,599		20				12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Book Depreciation					1,560,269		1,560,269		12,539,862	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)		\$29,851,684	\$1,560,269		\$1,560,269	\$	\$12,539,862	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	\$1,962,369	\$	\$	\$	20	\$	71
72	Current Year Purchases	15,573				20		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,977,942	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$34,104,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,560,269	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,560,269	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)	\$12,539,862	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 13,089 Description: Copier/Fax
(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

* 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.

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	\$

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)	\$			

(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.

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	

(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	39-1	hrs	\$ 293,021		\$	\$		\$ 293,021	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	82,638					82,638	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	391,068					391,068	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				202,592		202,592	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/Xray/RT/Equipme	39-3				183,525			183,525	12
13	Other (specify): O2/Therapy Supplies	39-2					71,492		71,492	13
14	TOTAL			\$ 766,727		\$ 183,525	\$ 274,084		\$ 1,224,336	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 914,066	\$ 1,009,820	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (975,279))	3,640,046	3,640,046	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,435	223,064	6
7	Other Prepaid Expenses	29,727	29,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		6,120,681	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,653,274	\$ 11,023,338	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,275,000	13
14	Buildings, at Historical Cost		21,399,034	14
15	Leasehold Improvements, at Historical Cost	202,265	2,225,428	15
16	Equipment, at Historical Cost	309,038	7,556,363	16
17	Accumulated Depreciation (book methods)	(195,112)	(12,539,862)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	38,254	38,254	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(33,501)	(33,501)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	21,936	21,936	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 342,880	\$ 20,942,652	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,996,154	\$ 31,965,990	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,508,740	\$ 1,508,740	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		333,119	29
30	Accrued Salaries Payable	815,998	815,998	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,972	307,251	32
33	Accrued Interest Payable		81,183	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	481,136	481,136	36
37	See Attached	5,432,195	5,432,195	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,247,041	\$ 8,959,622	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	175,000	175,000	39
40	Mortgage Payable		23,940,855	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)	\$ 175,000	\$ 24,115,855	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,422,041	\$ 33,075,477	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,425,887)	\$ (1,109,487)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,996,154	\$ 31,965,990	48

*(See instructions.)

Line #	Other Current Assets:	Amount	Amount
9			
9	Due from Associated Propco		3,102,680
9	Due from Thrive Lake County		400,000
9	MIP Escrow		78,114
9	Replacement Reserve		337,646
9	Other Receivables		2017308
9	Insurance Escrow		47873
9	Due to/From IH KCB Mundelein		5000
9	Real Estate Escrow		132060
	Total Line 9	-	6,120,681

Line #	Other Non-Current Assets:	Amount	Amount
23			0
	CIP	21,936	21,936
	Total Line 23	21,936	21,936

Line #	Other Current Liabilities:	Amount	Amount
36	Accrued Management Fee	2,514,487	2,514,487
36	Accrued Bed Tax	14,247	14,247
36	Accrued Expenses	209,585	209,585
36	Garnishments Clearing Account	5,650	5,650
36	Unclaimed Property	206	206
36			
36			
	Total Line 36	2,744,175	2,744,175
37	Due to/from IH KCB Mundelein Owner, LLC (Propco	5,432,195	5,432,195
	Total Line 37	5,432,195	5,432,195

Line #	Other Non-Current Liabilities:	Amount	Amount
43			
43			
43			
	Total Line 43	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,978,376)	1
2	Restatements (describe):		2
3			3
4	PY Restatement	(3,001)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,981,377)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(444,510)	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)	\$ (444,510)	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)	\$ (3,425,887)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Thrive of Lake County

0056655

Report Period Beginning: 1/1/2025

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	\$ 19,064,629	1
2	Discounts and Allowances for all Levels	(4,173,701)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,890,928	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,136,686	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,136,686	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	139,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,691	19
20	Radiology and X-Ray	11,231	20
21	Other Medical Services	220,466	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 465,962	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	641	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 641	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Quality Incentive Income	209,711	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 209,711	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,703,928	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,226,331	31
32	Health Care	8,002,730	32
33	General Administration	6,675,877	33
	B. Capital Expense		
34	Ownership	2,102,191	34
	C. Ancillary Expense		
35	Special Cost Centers	1,224,336	35
36	Provider Participation Fee	916,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,148,438	40
41	Income before Income Taxes (line 30 minus line 40)**	(444,510)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (444,510)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 8,846,251.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	412,134.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	18,543.00	47
48	Private Pay	1,992,099.00	48
49	Medicare Part A	1,146,966.00	49
50	Other-(specify) Medicare Part B	136,782.00	50
51	Other-(specify) Managed Care	2,338,153.00	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)	\$ 14,890,928	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,153	2,196	\$ 131,820	\$ 60.03	1
2	Assistant Director of Nursing	6,009	6,158	318,668	51.75	2
3	Registered Nurses	48,478	50,070	2,340,986	46.75	3
4	Licensed Practical Nurses	31,913	32,736	1,363,475	41.65	4
5	CNAs & Orderlies	89,185	90,723	2,940,741	32.41	5
6	CNA Trainees					6
7	Licensed Therapist	17,906	18,196	766,727	42.14	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,483	4,568	111,257	24.36	10
11	Social Service Workers	1,629	1,671	94,481	56.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,089	2,141	63,795	29.80	14
15	Cook Helpers/Assistants	23,939	24,295	546,455	22.49	15
16	Dishwashers	778	778	15,022	19.31	16
17	Maintenance Workers	3,986	4,093	133,360	32.58	17
18	Housekeepers	14,992	15,216	305,066	20.05	18
19	Laundry					19
20	Administrator	1,781	1,834	130,978	71.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,748	11,981	378,048	31.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,046	2,100	45,317	21.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,115	268,756	\$ 9,686,196 *	\$ 36.04	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 30,546	1-3	35
36	Medical Director	Monthly	41,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	27,517	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 99,563		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.

STATE OF ILLINOIS

Facility Name & ID NumberThrive of Lake County# 0056655Report Period Beginning:1/1/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

NameFunctionOwnership%

Amount

Anne BergAdministrator0

\$130,978

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.)

\$130,978

B. Administrative - Other

DescriptionAmount

Ignite Team Partners1,044,235

IH Asset Management93,592

TOTAL (agree to Schedule V, line 17, col. 3)
(Attach a copy of any management service agreement)

\$1,137,827

C. Professional Services

Vendor/PayeeTypeAmount

VariousAccounting Fees30,000

VariousLegal Fees298,919

VariousProfessional Fees106,445

TOTAL (agree to Schedule V, line 19, column 3)
(For legal fee disclosure, see page 39 of instructions)

\$435,364

D. Employee Benefits and Payroll Taxes

DescriptionAmount

Workers' Compensation Insurance161,113

Unemployment Compensation Insurance75,812

FICA Taxes720,482

Employee Health Insurance1,009,424

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*401K30,121

Other Employee Benefits25,742

Uniforms17,790

Supplemental Insurance3,748

TOTAL (agree to Schedule V, line 22, col.8)

\$2,044,232

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

DescriptionLine #Amount

TOTAL

F. Dues, Fees, Subscriptions and Promotions

DescriptionAmount

IDPH License Fee

Advertising: Employee Recruitment43,548

Health Care Worker Background Check3,718

(Indicate # of checks performed)5,914

Patient Background Checks

Association Dues (total from pg 22, #4)15,454

Dues and Subscriptions2,022

Licenses and Permits6,108

Less: Public Relations Expense

PAC and Lobbying payments(7,727)

All non-allowable advertising

TOTAL (agree to Sch. V, line 20, col. 8)

\$69,037

G. Schedule of Travel and Seminar**

DescriptionAmount

Out-of-State Travel

In-State Travel

Seminar Expense63,897

Entertainment Expense

TOTAL (agree to Sch. V, line 24, col. 8)

\$63,897

* Attach copy of IMRF notifications

**See instructions.

Date Description	Vendor	Amount
662000 - IMPORTED - Divvy CC Statement January 2024 Summary Entry	Legal Fees	1,477.90
662000 - Bills - S117: 2025/01/22 Batch Summary Entry	Legal Fees	172
662000 - To accrue Much Shelist invoice #630593	Legal Fees	9,133.00
662000 - Bills - S117: 2025/02/01 Batch Summary Entry	Legal Fees	1,412.50
662000 - Bills - S117: 2025/02/01 Batch Summary Entry	Legal Fees	8,526.00
662000 - Bills - S117: 2025/02/19 Batch Summary Entry	Legal Fees	3,563.00
662000 - Bills - S117: 2025/02/21 Batch Summary Entry	Legal Fees	10,494.00
662000 - Bills - S117: 2025/02/25 Batch Summary Entry	Legal Fees	1,426.00
662000 - Bills - S117: 2025/03/01 Batch Summary Entry	Legal Fees	8,084.00
662000 - Bills - S117: 2025/03/17 Batch Summary Entry	Legal Fees	5,019.58
662000 - Bills - S117: 2025/03/21 Batch Summary Entry	Legal Fees	405
662000 - Bills: 2025/03/27 Batch Summary Entry	Legal Fees	133.33
662000 - IMPORTED - Divvy CC Statement April 2025 Summary Entry	Legal Fees	350
662000 - Bills - S117: 2025/04/21 Batch Summary Entry	Legal Fees	22,881.00
662000 - Bills - S117: 2025/04/23 Batch Summary Entry	Legal Fees	202.5
900034 - To reclass Cintas AP Adjustment (posted in March)	Legal Fees	-5,706.47
662000 - Bills - S117: 2025/05/14 Batch Summary Entry	Legal Fees	1,563.50
662000 - Bills - S117: 2025/05/16 Batch Summary Entry	Legal Fees	35,422.00
662000 - Bills - S117: 2025/06/01 Batch Summary Entry	Legal Fees	673.43
662000 - Bills - S117: 2025/06/01 Batch Summary Entry	Legal Fees	19,031.00
662000 - Bills - S117: 2025/06/16 Batch Summary Entry	Legal Fees	2,832.00
662000 - Bills - S117: 2025/06/17 Batch Summary Entry	Legal Fees	456
662000 - Bills - S117: 2025/06/20 Batch Summary Entry	Legal Fees	1,212.00
662000 - Bills - S117: 2025/06/20 Batch Summary Entry	Legal Fees	174
662000 - Bills: 2025/06/23 Batch Summary Entry	Legal Fees	614.34
662000 - Bills - S117: 2025/07/01 Batch Summary Entry	Legal Fees	1,007.50
662000 - Bills - S117: 2025/07/07 Batch Summary Entry	Legal Fees	840
662000 - Bills - S117: 2025/07/13 Batch Summary Entry	Legal Fees	2,848.50
662000 - Bills - S117: 2025/07/14 Batch Summary Entry	Legal Fees	39,534.26
662000 - Bills - S117: 2025/07/24 Batch Summary Entry	Legal Fees	81
662000 - Bills - S117: 2025/07/29 Batch Summary Entry	Legal Fees	11,531.91
662000 - Bills - S117: 2025/07/31 Batch Summary Entry	Legal Fees	3,007.00
662000 - Bills - S117: 2025/08/11 Batch Summary Entry	Legal Fees	22,547.71
662000 - Bills - S117: 2025/08/14 Batch Summary Entry	Legal Fees	510
662000 - Bills - S117: 2025/09/01 Batch Summary Entry	Legal Fees	715
662000 - Bills - S117: 2025/09/08 Batch Summary Entry	Legal Fees	440
662000 - Bills - S117: 2025/09/10 Batch Summary Entry	Legal Fees	6,133.50
662000 - Bills - S117: 2025/09/16 Batch Summary Entry	Legal Fees	191.69
662000 - Bills - S117: 2025/09/25 Batch Summary Entry	Legal Fees	53
662000 - Bills - S117: 2025/10/21 Batch Summary Entry	CT Corporation System	228
Amundsen Davis 838266	Amundsen Davis 838266	6,737.00
Amundsen Davis	Amundsen Davis	50,000.00
CT Corporation System	CT Corporation System	228
Polsinelli PC	Polsinelli PC	12,234.89
5137-API-000000927	5137-API-000000927	10,498.35
Total		298,918.92

Date	Description	Amount
1/31/2025	600530 - Paylocity Payroll	25.00
1/31/2025	600530 - Paylocity Payroll	5.00
1/31/2025	600530 - Paylocity Payroll	5.00
1/31/2025	600530 - IMPORTED - Divvy CC Statement January 2024 Summary Entry	1,886.18
1/31/2025	600530 - Paylocity Payroll	25.00
1/31/2025	600530 - Paylocity Payroll	5.00
1/31/2025	600530 - Bills - S117: 2025/01/29 Batch Summary Entry	269.70
1/31/2025	600530 - Bills - 2025/01/29 Batch Summary Entry	104.55
1/31/2025	600530 - Bills - S117: 2025/01/31 Batch Summary Entry	269.95
1/31/2025	600530 - Bills - 2025/01/31 Batch Summary Entry	286.65
1/31/2025	600530 - To accrue 2025 Retreat	500.00
2/28/2025	600530 - Paylocity Payroll	25.00
2/28/2025	600530 - Paylocity Payroll	5.00
2/28/2025	600530 - IMPORTED - Divvy CC Statement February 2024 Summary Entry	1,444.05
2/28/2025	600530 - Paylocity Payroll	25.00
2/28/2025	600530 - Paylocity Payroll	5.00
2/28/2025	600530 - Bills - S117: 2025/02/28 Batch Summary Entry	1,074.02
2/28/2025	600530 - Bills - 2025/02/28 Batch Summary Entry	220.15
2/28/2025	600530 - To accrue 2025 Retreat	500.00
2/28/2025	600530 - IMPORTED - February 2025 Chase Expense Report Summary Entry	192.80
3/31/2025	600510 - IMPORTED - Divvy CC Statement March 2025 Summary Entry	56.87
3/31/2025	600530 - Paylocity Payroll	25.00
3/31/2025	600530 - Paylocity Payroll	5.00
3/31/2025	600530 - IMPORTED - Divvy CC Statement March 2025 Summary Entry	3,088.87
3/31/2025	600530 - Bills - S117: 2025/03/31 Batch Summary Entry	316.15
3/31/2025	600530 - Paylocity Payroll	25.00
3/31/2025	600530 - Paylocity Payroll	5.00
3/31/2025	600530 - Bills - S117: 2025/03/26 Batch Summary Entry	98.66
3/31/2025	600530 - Bills - S117: 2025/03/31 Batch Summary Entry	2,209.48
3/31/2025	600530 - To accrue 2025 Retreat	500.00
3/31/2025	600530 - Bills - 2025/03/31 Batch Summary Entry	240.78
3/31/2025	600530 - IMPORTED - March 2025 Chase Expense Report Summary Entry	860.38
3/31/2025	To reduce Brian Promotional Solutions (Brian A Company Inc) Invoice #547	857.28
4/30/2025	600530 - Paylocity Payroll	25.00
4/30/2025	600530 - Paylocity Payroll	5.00
4/30/2025	600530 - IMPORTED - Divvy CC Statement April 2025 Summary Entry	2,873.45
4/30/2025	600530 - Paylocity Payroll	25.00
4/30/2025	600530 - Paylocity Payroll	5.00
4/30/2025	600530 - Bills - S117: 2025/04/28 Batch Summary Entry	506.14
4/30/2025	600530 - To accrue 2025 Retreat	500.00
4/30/2025	600530 - Bills - 2025/04/30 Batch Summary Entry	239.29
5/31/2025	600510 - Bills - 2025/05/01 Batch Summary Entry	289.46
5/31/2025	600510 - IMPORTED - Divvy CC Statement May 2025 Summary Entry	45.64
5/31/2025	600530 - Lake County Payroll 05.08.25	20.00
5/31/2025	600530 - Lake County Payroll 05.08.25	5.00
5/31/2025	600530 - Bills - 2025/05/14 Batch Summary Entry	123.80
5/31/2025	600530 - IMPORTED - Divvy CC Statement May 2025 Summary Entry	1,400.36
5/31/2025	600530 - Bills - S117: 2025/05/15 Batch Summary Entry	686.10
5/31/2025	600530 - Lake County Payroll 05.23.25	20.00
5/31/2025	600530 - Lake County Payroll 05.23.25	5.00
5/31/2025	600530 - Bills - S117: 2025/05/28 Batch Summary Entry	257.06
5/31/2025	600530 - Bills - S117: 2025/06/30 Batch Summary Entry	100.52
5/31/2025	600530 - To accrue 2025 Retreat	500.00
5/31/2025	600530 - Bills - 2025/06/31 Batch Summary Entry	266.48
5/31/2025	600530 - IMPORTED - May 2025 Chase Expense Report Summary Entry	1,760.78
5/31/2025	600530 - To accrue additional 2025 Clinical Retreat	-123.26
6/30/2025	600530 - Bills - S117: 2025/06/01 Batch Summary Entry	242.35
6/30/2025	600530 - Bills - S117: 2025/06/01 Batch Summary Entry	107.62
6/30/2025	600530 - Lake County Payroll 06.09.25	20.00
6/30/2025	600530 - Lake County Payroll 06.09.25	5.00
6/30/2025	600530 - IMPORTED - Divvy CC Statement June 2025 Summary Entry	1,290.37
6/30/2025	600530 - Lake County Payroll 06.23.25	20.00
6/30/2025	600530 - Lake County Payroll 06.23.25	5.00
6/30/2025	600530 - Bills - S117: 2025/06/24 Batch Summary Entry	804.55
6/30/2025	600530 - Bills - S117: 2025/06/26 Batch Summary Entry	281.83
6/30/2025	600530 - Bills - S117: 2025/06/30 Batch Summary Entry	381.92
6/30/2025	600530 - To accrue 2025 Retreat	500.00
6/30/2025	600530 - To accrue additional 2025 Clinical Retreat	-123.26
6/30/2025	600530 - To accrue additional 2025 Clinical Retreat	440.19
6/30/2025	600530 - IMPORTED - June 2025 Chase Expense Report Summary Entry	100.00
7/31/2025	600510 - Bills - 2025/07/10 Batch Summary Entry	43.82
7/31/2025	600510 - IMPORTED - Divvy CC Statement July 2025 Summary Entry	305.35
7/31/2025	600530 - Bills - S117: 2025/07/01 Batch Summary Entry	688.33
7/31/2025	600530 - Lake County 07.08.25	20.00
7/31/2025	600530 - Lake County 07.08.25	5.00
7/31/2025	600530 - Bills - S117: 2025/07/15 Batch Summary Entry	75.93
7/31/2025	600530 - IMPORTED - Divvy CC Statement July 2025 Summary Entry	387.84
7/31/2025	600530 - Lake County 07.23.25	20.00
7/31/2025	600530 - Lake County 07.23.25	5.00
7/31/2025	600530 - To accrue 2025 Retreat	500.00
7/31/2025	600530 - To accrue additional 2025 Clinical Retreat	-123.26
7/31/2025	600530 - Bills - 2025/07/31 Batch Summary Entry	225.71
7/31/2025	600530 - IMPORTED - July 2025 Chase Expense Report Summary Entry	440.19
8/31/2025	600510 - IMPORTED - Divvy CC Statement August 2025 Summary Entry	87.98
8/31/2025	600530 - FED REF=020651 LTW+G1GG736C TTM=2025/08/05 10:20 RECEIVED AT F	308.50
8/31/2025	600530 - Lake County 08.08.25	15.00
8/31/2025	600530 - Lake County 08.08.25	5.00
8/31/2025	600530 - Bills - S117: 2025/08/13 Batch Summary Entry	732.16
8/31/2025	600530 - IMPORTED - Divvy CC Statement August 2025 Summary Entry	450.30
8/31/2025	600530 - Lake County 08.22.25	15.00
8/31/2025	600530 - Lake County 08.22.25	5.00
8/31/2025	600530 - Bills - S117: 2025/08/28 Batch Summary Entry	1,088.09
8/31/2025	600530 - To accrue 2025 Retreat	500.00
8/31/2025	600530 - To accrue additional 2025 Clinical Retreat	-123.26
8/31/2025	600530 - Bills - 2025/08/31 Batch Summary Entry	239.14
8/31/2025	600530 - To Accrue Time August 2025 Chase Expense	440.19
8/31/2025	600532 - Lake County 08.08.25	4,000.00
8/30/2025	600510 - IMPORTED - Divvy CC Statement September 2025 Summary Entry	199.57
8/30/2025	600530 - IMPORTED - August 2025 Chase Expense Summary Entry	440.19
8/30/2025	600530 - Reversal - To Accrue Time August 2025 Chase Expense	-440.19
8/30/2025	600530 - Lake County 09.08.25	15.00
8/30/2025	600530 - Lake County 09.08.25	5.00
8/30/2025	600530 - Bills - 2025/09/12 Batch Summary Entry	20,000.00
8/30/2025	600530 - IMPORTED - Divvy CC Statement September 2025 Summary Entry	2,616.51
8/30/2025	600530 - Lake County Payroll 09.23.25	20.00
8/30/2025	600530 - Lake County Payroll 09.23.25	3.51
8/30/2025	600530 - Lake County Payroll 09.23.25	6.49
8/30/2025	600530 - To accrue 2025 Retreat	500.00
8/30/2025	600530 - To accrue additional 2025 Clinical Retreat	-123.26
8/30/2025	600530 - IMPORTED - September 2025 Chase Expense Report Summary Entry	440.19
8/30/2025	600530 - To expense remaining 2025 Clinical retreat balance	1,130.23
8/30/2025	600535 - Bills - S117: 2025/09/01 Batch Summary Entry	60.00
10/31/2025	600530 - Lake County 10.08.25	20.00
10/31/2025	600530 - Lake County 10.08.25	5.00
10/31/2025	600530 - Lake County 10.08.25	5.00
10/31/2025	PE 2025-10-15 CD 2025-10-23	20.00
10/31/2025	PE 2025-10-15 CD 2025-10-23	5.00
10/31/2025	PE 2025-10-15 CD 2025-10-23	0.00
10/31/2025	PE 2025-10-31 CD 2025-11-07	20.00
10/31/2025	PE 2025-10-31 CD 2025-11-07	4.13
10/31/2025	PE 2025-10-31 CD 2025-11-07	5.87
11/30/2025	PE 2025-11-15 CD 2025-11-24	20.00
11/30/2025	PE 2025-11-15 CD 2025-11-24	0.99
11/30/2025	PE 2025-11-15 CD 2025-11-24	6.31
11/30/2025	PE 2025-11-30 CD 2025-12-08	20.00
11/30/2025	PE 2025-11-30 CD 2025-12-08	20.00
11/30/2025	PE 2025-11-30 CD 2025-12-08	4.33
11/30/2025	PE 2025-11-30 CD 2025-12-08	5.67
11/30/2025	Amex 7/01 1-0137	380.00
12/31/2025	PE 2025-12-15 CD 2025-12-23	20.00
12/31/2025	PE 2025-12-15 CD 2025-12-23	3.72
12/31/2025	PE 2025-12-15 CD 2025-12-23	6.28
12/31/2025	PE 2025-12-31 CD 2025-01-08	20.00
12/31/2025	PE 2025-12-31 CD 2025-01-08	-4.35
12/31/2025	PE 2025-12-31 CD 2025-01-08	5.65
Totals		61,566.88

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

Amount

HEALTH CARE COUNCIL OF IL (HCCI)

7,727

7,727

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.

HEALTH CARE COUNCIL OF IL (HCCI)

7,727

7,727

Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

15,454

15,454

Total
- (5)

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

\$ 135,000 Line 10
- (6)

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

Yes

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

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

\$ 916,973

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

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

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

No

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

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

\$ N/A Has any meal income been offset against
related costs? Indicate the amount. \$
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a
program during this reporting period. \$ N/A

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

LN 14

d. Have vehicle usage logs been maintained?

No

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

N/A

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

N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$ N/A

No
- (13)

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

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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