

		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: 0048256

Facility Name: The Village at Victory Lakes

Address: 1055 East Grand Ave Lindenhurst 60046

NumberCityZip Code

County: Lake

Telephone Number: 847-356-5900 Fax # 847-356-4599

HFS ID Number:

Date of Initial License for Current Owners: 04/19/1965

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:

Name: Matt Larsh Telephone Number: 630-368-3666

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)	Robert Rosenberger		
	(Title)	CFO		
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)	Matthew Larsh Signing Director		
	(Firm Name & Address)	CLA 833 West Lincoln Highway, Suite 210W, Schererville, IN 463		
	(Telephone)	630-368-3666	Fax #	219-864-0055
	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

The Village at Victory Lakes

#

0048256

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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	2,096	4,692	730	252	9,806	9,198	6,708	33,482	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,096	4,692	730	252	9,806	9,198	6,708	33,482	14

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

76.44%

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 07/12/2016

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

YES ☒ Date 07/12/2016 NO ☐

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

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL ☒ 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.

Facility Name & ID Number The Village at Victory Lakes # 0048256 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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		29,490	1,132,201	1,161,691		1,161,691	32,665	1,194,356			1
2	Food Purchase		545,986		545,986		545,986	(18,908)	527,078			2
3	Housekeeping	143,674	27,368	9,190	180,232		180,232	(6,202)	174,030			3
4	Laundry		3,549		3,549		3,549		3,549			4
5	Heat and Other Utilities			146,143	146,143		146,143		146,143			5
6	Maintenance	129,695	19,273	175,176	324,144		324,144	18,801	342,945			6
7	Other (specify):*											7
8	TOTAL General Services	273,369	625,666	1,462,710	2,361,745		2,361,745	26,356	2,388,101			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	4,996,060	347,448	734,854	6,078,362		6,078,362		6,078,362			10
10a	Therapy											10a
11	Activities	56,896	1,067	991	58,954		58,954	60,102	119,056			11
12	Social Services	196,175	797	21,623	218,595		218,595	(300)	218,295			12
13	CNA Training											13
14	Program Transportation	28,588	3,220	4,826	36,634		36,634		36,634			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,277,719	352,532	784,294	6,414,545		6,414,545	59,802	6,474,347			16
	C. General Administration											
17	Administrative	290,599	15,307	1,180,844	1,486,750		1,486,750	(1,022,042)	464,708			17
18	Directors Fees											18
19	Professional Services			68,809	68,809		68,809	263,077	331,886			19
20	Dues, Fees, Subscriptions & Promotions			71,308	71,308		71,308	6,972	78,280			20
21	Clerical & General Office Expenses	289,542	1,034	687,357	977,933		977,933	292,547	1,270,480			21
22	Employee Benefits & Payroll Taxes			1,628,775	1,628,775		1,628,775	214,313	1,843,088			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,565	5,565		5,565	25,116	30,681			24
25	Other Admin. Staff Transportation			13,977	13,977		13,977		13,977			25
26	Insurance-Prop.Liab.Malpractice			137,207	137,207		137,207	23,318	160,525			26
27	Other (specify):*											27
28	TOTAL General Administration	580,141	16,341	3,793,842	4,390,324		4,390,324	(196,699)	4,193,625			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,131,229	994,539	6,040,846	13,166,614		13,166,614	(110,541)	13,056,073			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			489,174	489,174		489,174	4,815	493,989			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			178,375	178,375		178,375	(68)	178,307			32
33	Real Estate Taxes			291,662	291,662		291,662	(9)	291,653			33
34	Rent-Facility & Grounds							7,999	7,999			34
35	Rent-Equipment & Vehicles			58,563	58,563		58,563	483	59,046			35
36	Other (specify):*											36
37	TOTAL Ownership			1,017,774	1,017,774		1,017,774	13,220	1,030,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,014,679	1,889,174	2,903,853		2,903,853		2,903,853			39
40	Barber and Beauty Shops	32,178	463		32,641		32,641	(32,641)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			440,525	440,525		440,525		440,525			42
43	Other (specify):* AL/IL/Marketing	3,359,960	15,602	7,871,893	11,247,455		11,247,455	(11,247,455)				43
44	TOTAL Special Cost Centers	3,392,138	1,030,744	10,201,592	14,624,474		14,624,474	(11,280,096)	3,344,378			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,523,367	2,025,283	17,260,212	28,808,862		28,808,862	(11,377,417)	17,431,445			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	(18,908)	2		4
5	Telephone, TV & Radio in Resident Rooms	(43,658)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,202)	3		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(68)	32		10
11	Discounts, Allowances, Rebates & Refunds	(724)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(510)	21		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	(5,436)	21		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	(292,566)	21		24
25	Fund Raising, Advertising and Promotional	(407,881)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,016,465)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,792,427)		\$	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)	1,415,010	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,415,010		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (11,377,417)		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	Barber and Beauty	(32,641)	40	4
5	Other Income - Life Enrichment	(300)	12	5
6	Other Income - Plant	(2,252)	6	6
7	AL/IL - Salary	(3,156,734)	43	7
8	AL/IL - Supplies & Other	(7,682,840)	43	8
9	Miscellaneous Expense	(343)	21	9
10	Legal Settlements	(39,375)	19	10
11	Miscellaneous Revenue	(2,468)	21	11
12				12
13	Home Office AL/IL Expenses			13
14	Dietary	(37,735)	01	14
15	Maintenance	(70,486)	06	15
16	Activities	(131,306)	11	16
17	Administrative	(90,299)	17	17
18	Professional Fees	(171,982)	19	18
19	Dues & Subscriptions	(3,965)	20	19
20	A&G	(362,927)	21	20
21	A&G Benefits	(147,092)	22	21
22	Seminar and Travel	(14,282)	24	22
23	Insurance	(13,259)	26	23
24	Depreciation	(16,115)	30	24
25	RE Taxes	(11,668)	33	25
26	Rental - Facility & Grounds	(26,777)	34	26
27	Rent - Equipment	(1,619)	35	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	(12,016,465)		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[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
		Franciscan Village	Lemont, IL	Franciscan Sisters of C	Lemont, IL	Religious Cong.
		Mt. Alverna Village/ Ancora	Parma, OH	Franciscan Sisters Chi	Lemont, IL	Corp. Management
		Addolorata Villa	Wheeling, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living
		St. Joseph Village	Chicago, IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.
		University Place	West Lafayette, IN	St. Jude House	Crown Point, IN	Dom. Viol. Shelter
				Madonna Foundation	Lemont, IL	HS Foundation
				Village at Mercy Creel	Normal, IL	Ind. & Asst. Living

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

X 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	17	Management Fees	\$ 1,180,844		100.00%	\$	(1,180,844)	15
16	V	1	Dietary - Salaries			100.00%	70,400	70,400	16
17	V	6	Maintenance - Salaries			100.00%	68,590	68,590	17
18	V	6	Maintenance - Other			100.00%	22,949	22,949	18
19	V	11	Activities - Salaries			100.00%	191,408	191,408	19
20	V	17	Administrative - Salaries			100.00%	249,101	249,101	20
21	V	19	Professional Fees			100.00%	474,434	474,434	21
22	V	20	Dues & Subscriptions			100.00%	10,937	10,937	22
23	V	21	Clerical - Salaries			100.00%	809,657	809,657	23
24	V	21	Clerical - Other			100.00%	191,522	191,522	24
25	V	22	Employee Benefits			100.00%	361,405	361,405	25
26	V	24	Seminar & Travel			100.00%	39,398	39,398	26
27	V	26	Professional Fees			100.00%	36,577	36,577	27
28	V	30	Depreciation			100.00%	20,930	20,930	28
29	V	33	Real Estate Taxes			100.00%	11,668	11,668	29
30	V	34	Lease/Rent - Building			100.00%	34,776	34,776	30
31	V	35	Lease/Rent - Equipment			100.00%	2,102	2,102	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,180,844			\$ 2,595,854	\$ * 1,415,010	39

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

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
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

Ending: 6/30/2025

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	1	Dietary - Salaries	Expense	146,728,265	10	\$ 382,592	\$ 382,592	26,999,290	\$ 70,400	1
2	6	Maintenance - Salaries	Expense	146,728,265	10	372,756	372,756	26,999,290	68,590	2
3	6	Maintenance - Other	Expense	146,728,265	10	124,716		26,999,290	22,949	3
4	11	Activities - Salaries	Expense	146,728,265	10	1,040,211	1,040,211	26,999,290	191,408	4
5	17	Administrative - Salaries	Expense	146,728,265	10	1,353,747	1,353,747	26,999,290	249,101	5
6	19	Professional Fees	Expense	146,728,265	10	2,578,323		26,999,290	474,434	6
7	20	Dues & Subscriptions	Expense	146,728,265	10	59,436		26,999,290	10,937	7
8	21	Clerical - Salaries	Expense	146,728,265	10	4,400,097	4,400,097	26,999,290	809,657	8
9	21	Clerical - Other	Expense	146,728,265	10	1,040,830		26,999,290	191,522	9
10	22	Employee Benefits	Expense	146,728,265	10	1,964,064		26,999,290	361,405	10
11	24	Seminar & Travel	Expense	146,728,265	10	214,111		26,999,290	39,398	11
12	26	Insuance	Expense	146,728,265	10	198,778		26,999,290	36,577	12
13	30	Depreciation	Expense	146,728,265	10	113,743		26,999,290	20,930	13
14	33	Real Estate Taxes	Expense	146,728,265	10	63,411		26,999,290	11,668	14
15	34	Lease/Rent - Building	Expense	146,728,265	10	188,991		26,999,290	34,776	15
16	35	Lease/Rent - Equipment	Expense	146,728,265	10	11,424		26,999,290	2,102	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 14,107,230	\$ 7,549,403		\$ 2,595,854	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	Illinios Finance Authority		X	Refinanced Debt	Varies	06/28/2017	\$ 5,499,360	\$ 4,574,250	05/15/2047	4.8600	\$ 234,843	1	
2	Illinios Finance Authority		X	Refinanced Debt	Varies	10/14/2021	5,422,581	5,234,481	05/15/2050	4.9900	114,835	2	
3	Illinios Finance Authority		X	Refinanced Debt	Varies	05/15/2023	12,150,405	11,884,500	05/15/2047	2.2800	431,958	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 23,072,346	\$ 21,693,231			\$ 781,636	9	
	B. Non-Facility Related*												
10	Interest Income										(68)	10	
11	Alloc. Non-Allowable AI/IL										(597,167)	11	
12	Allocation variance										(6,094)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (603,329)	14	
15	TOTALS (line 9+line14)						\$ 23,072,346	\$ 21,693,231			\$ 178,307	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.)

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	<u>The Village at Victory Lakes</u>	COUNTY	<u>Lake</u>
---------------	-------------------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Matt Larsh

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,454 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 2

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Independent Living - 131,881 Square Feet (100 Units)
Independent Living - 59,410 Square Feet (40 Garden Home Duplex Units)
Assisted Living - 51,631 Square Feet (84 Units)

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?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2006	\$ 738,341	1
2					2
3	TOTALS			\$ 738,341	3

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	204		2006	1998	\$ 8,522,869	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2006		1,188					9
10	Various		2007		11,024					10
11	Various		2008		33,383					11
12	Various		2009		21,896					12
13	Various		2010		62,243					13
14	Various		2011		124,728					14
15	Various		2012		50,848					15
16	Various		2013		157,246					16
17	Various		2014		78,742					17
18	Various		2015		7,581					18
19	Various		2016		1,274,990					19
20	Various		2017		1,159,104					20
21	Various		2018		77,612					21
22	Various		2019		1,827,734					22
23	Various		2020		24,716					23
24	Various		2021		75,800					24
25	CCG Group - Exterior Canopy MainEntrance - (Total cost: 8500)		2022		1,953					25
26	ParmontEO - Electrical - (Total cost: 4123.38)		2022		947					26
27	Door Systems Assas-facility front door repairs-(Total Cost:2538)		2022		561					27
28	Krause Electrical - fix parking lot lights - (Total Cost: 17054)		2022		3,772					28
29	Zentel Tech - Chiller - (Total cost: 135000)		2023		31,015					29
30	Zentel Tech Chiller install - (Total cost: 90930)		2023		20,890					30
31	Zentel Tech - Chiller - (Total cost: 20597)		2023		4,732					31
32	Siemens - Building Automation System - (Total cost: 228881.22)		2023		52,583					32
33	Lionheart Critical Power-belts, pressure gauge(Total Cost: 2819)		2023		624					33
34	Lionheart Critical Power-Generator Maint-(Total Cost:3682)		2023		815					34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Village at Victory Lakes

0048256

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Lakeland Larson - Elevator Modernization -Elevator - (TC: 12053	2023	\$ 2,666	\$		\$	\$	\$	37
38	Defranco Plumbing - Water Boost System -Pump - (TC: 67506)	2023	14,932						38
39	Centrury Sprinkler Attic Dry System -Sprinksys - (TC: 14206)	2023	3,142						39
40	Tee Jay Srvc - Door Control Main Lobby -Controls - (TC: 2952)	2023	2,952						40
41	Midwest Mech Air Handler Pump-HVACCompste -(TC: 5767.06)	2024	1,276						41
42	Thermostat Acq- Hot Water Return Pump -Pump - (TC: 3708)	2024	820						42
43	Landmark Sign Group Signage -Signage - (Total Cost: 59715.58)	2024	13,208						43
44									44
45									45
46	CCG Group1 Inc Loading Dock Repair (\$15,000)	2025	3,446						46
47	LVS IT Capital Project (\$68,940)	2025	15,836						47
48	Direct Supply Tabletop (\$2,457)	2025	564						48
49	Unidine Steamer/countertop Install (\$25,835)	2025	5,934						49
50	Industrial Door - Stairwell to Courtyard (\$4,776)	2025	1,097						50
51	S Bowers CC 02.2025 (\$703)	2025	703						51
52	TNS - Fiber Optics (\$12,735)	2025	2,925						52
53	Northshore Plumbing - Sump System (\$9,400)	2025	2,159						53
54	Defranco Plumbing - Plumbing (\$6,136)	2025	1,409						54
55	EOC Audio - Handheld Microphone (\$2,431)	2025	558						55
56	EOC Audio - Handheld Microphone (\$608)	2025	140						56
57	Steve Bowers - July 2024 CC (\$290)	2025	67						57
58	Steve Bowers - August 2024 CC (\$441)	2025	101						58
59	DeFranco Plumb Water Line Pipe (\$4,970)	2025	1,142						59
60	McCloud Aquatics Pond Pump Replace (\$4,668)	2025	1,072						60
61	EOC Audio - Camera Switcher (\$12,780)	2025	2,936						61
62	EOC Audio - Camera Switcher (\$3,685)	2025	847						62
63	Sound Inc - Control System & Maglocks (\$38,839)	2025	8,921						63
64	Krause Electrical - Exterior Signage (\$5,004)	2025	1,149						64
65	Century Automatic Sprinkler - Compressor (\$6,485)	2025	1,490						65
66	Defranco Plumbing - Water Heater (\$2,014)	2025	463						66
67	Defranco Plumbing - Water Heater (\$17,968)	2025	4,127						67
68	Briggs Paving - Asphalt Install (\$299,407)	2025	299,407						68
69	Pavement Management - Sealcoat (\$10,405)	2025	10,405						69
70	TOTAL (lines 4 thru 69)		\$ 14,035,490	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,035,490	\$		\$	\$	\$	1
2	Sound Incorp Door Reader (\$17,883)	2025	4,108						2
3	AffiliatedCustServInc Fire Alarm syst (\$29,865)	2025	6,860						3
4	Affiliated Cust Service IL/AL Fire Panel (\$20,490)	2025	4,707						4
5	Up N Adam - 3 Door Cooler Evap Coil (\$3,834)	2025	881						5
6									6
7									7
8									8
9	Depreciation			489,174		489,174		6,968,112	9
10									10
11	Alloc - FSCSC (Page 6A)					20,930	20,930		11
12	Non-Allowable HO Allocation					(16,115)	(16,115)		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	TOTAL (lines 1 thru 33)		\$ 14,052,046	\$ 489,174		\$ 493,989	\$ 4,815	\$ 6,968,112	34

**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	\$ 1,542,246	\$	\$	\$		\$	71
72	Current Year Purchases	148,498						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,690,744	\$	\$	\$		\$	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	Facility	Bus (TC = \$31,550+\$57,744)	2014-15	\$ 20,514	\$	\$	\$		\$	76
77	Facility	Truck (TC = \$47,705)	2017	10,960						77
78	Facility	Van (TC = \$34,246)	2018	34,346						78
79	Facility	2018 Ford Bus(TC=\$80,743)	2023	17,860						79
80	TOTALS			\$ 83,680	\$	\$	\$		\$	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)	\$ 16,564,811	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 489,174	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 493,989	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,815	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,968,112	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	Non-Care Assets - PY Total	\$ 13,363,610	\$	\$	86
87	Non-Care Assets - CY	735,738			87
88					88
89					89
90	Depreciation		1,637,673	23,107,400	90
91	TOTALS	\$ 14,099,348	\$ 1,637,673	\$ 23,107,400	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Renovation	\$ 187,058	92
93			93
94			94
95		\$ 187,058	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:				\$			3
4	Additions							4
5								5
6	Alloc - FSCSC				7,999			6
7	TOTAL				\$ 7,999			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: \$ 58,563 Description: See Attached and AL/IL Allocation
(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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$	8,712	\$ 673,033	\$	8,712	\$ 673,033	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		2,781	214,853		2,781	214,853	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		9,050	699,094		9,050	699,094	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3 / 2	# of prescrpts			14,464	996,168		1,010,632	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/Radiology/Resp/O	39-3 / 2				287,730	18,511		306,241	13
14	TOTAL			\$	20,543	\$ 1,889,174	\$ 1,014,679	20,543	\$ 2,903,853	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	\$ 82,862	\$	1
2	Cash-Patient Deposits	636		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 553,222)	1,572,567		3
4	Supply Inventory (priced at)	191,023		4
5	Short-Term Investments			5
6	Prepaid Insurance	233,317		6
7	Other Prepaid Expenses	169,412		7
8	Accounts Receivable (owners or related parties)	340		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,250,157	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,785,000		13
14	Buildings, at Historical Cost	39,379,510		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,897,587		16
17	Accumulated Depreciation (book methods)	(29,035,621)		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: CIP/Deferred Market)	299,696		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,326,172	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,576,329	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 158,002	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,029,228		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,149		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,107		31
32	Accrued Real Estate Taxes(Sch.IX-B)	379,139		32
33	Accrued Interest Payable			33
34	Deferred Compensation	76,704		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	See Attached TB	119,101		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 27,051,430	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 27,051,430	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (475,101)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,576,329	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (651,001)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (651,001)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,776	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) PY Adjustments	57,122	15
16	Other (describe)	2	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 175,900	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)	\$ (475,101)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Village at Victory Lakes

0048256

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

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	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 24,911,308	1
2	Discounts and Allowances for all Levels	(16,851,726)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,059,582	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,781,393	6
7	Oxygen	94,800	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,876,193	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	18,621	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,600	16
17	Sale of Drugs	1,013,691	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	129,674	19
20	Radiology and X-Ray	29,299	20
21	Other Medical Services	613,121	21
22	Laundry	19,752	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,827,758	23
	D. Non-Operating Revenue		
24	Contributions	10,120	24
25	Interest and Other Investment Income***	294	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,414	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. (See Attached Schedule)	12,153,691	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,153,691	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 28,927,638	30

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	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,361,745	31
32	Health Care	6,414,545	32
33	General Administration	4,390,324	33
	B. Capital Expense		
34	Ownership	1,017,774	34
	C. Ancillary Expense		
35	Special Cost Centers	14,183,949	35
36	Provider Participation Fee	440,525	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,808,862	40
41	Income before Income Taxes (line 30 minus line 40)**	118,776	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 118,776	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 450,622.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,198,106.00	45
46	MMAI-Medicaid is the Primary Payer	169,907.00	46
47	MMAI-Medicare is the Primary Payer	130,150.00	47
48	Private Pay	4,819,011.00	48
49	Medicare Part A	6,123,566.00	49
50	Other-(specify) Managed Care	3,458,673.00	50
51	Other-(specify) C/A Ancillary	-8,290,453.00	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)	\$ 8,059,582	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	2,046	2,274	\$ 124,458	\$ 54.73	1
2	Assistant Director of Nursing	166	175	8,856	50.61	2
3	Registered Nurses	37,270	39,271	1,602,630	40.81	3
4	Licensed Practical Nurses	23,401	25,299	839,152	33.17	4
5	CNAs & Orderlies	85,517	90,350	1,950,651	21.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	375	440	13,154	29.90	9
10	Activity Assistants	3,626	4,028	72,330	17.96	10
11	Social Service Workers	5,469	5,999	196,175	32.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,681	4,002	129,695	32.41	17
18	Housekeepers	6,934	7,695	143,674	18.67	18
19	Laundry					19
20	Administrator	3,343	3,722	290,599	78.08	20
21	Assistant Administrator					21
22	Other Administrative	2,894	3,177	116,962	36.82	22
23	Office Manager	822	980	35,329	36.05	23
24	Clerical	6,363	6,939	137,251	19.78	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	1,694	1,904	37,747	19.83	31
32	Other Health C: Nursing Admin	10,704	11,748	432,566	36.82	32
33	Other(specify) Marketing, AI/IL,	126,382	137,995	3,392,138	24.58	33
34	TOTAL (lines 1 - 33)	320,687	345,998	\$ 9,523,367 *	\$ 27.52	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		\$		35
36	Medical Director	monthly fee	22,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly fee	11,887	10-3	38
39	Pharmacist Consultant	monthly fee	10,714	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	monthly fee	522	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Organist/Priest	monthly fee	16,240	12-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 61,363		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,098	\$ 530,602	10-3	50
51	Licensed Practical Nurses	842	47,934	10-3	51
52	Certified Nurse Assistants/Aides	378	11,880	10-3	52
53	TOTAL (lines 50 - 52)	9,318	\$ 590,416		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|--------------------|---------------------|
| <u>LEADING AGE</u> | <u>21,541</u> |
| _____ | _____ |
| _____ | _____ |
| _____ | <u>21,541</u> 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.
- | | |
|--------------------|--------------------|
| <u>LEADING AGE</u> | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | <u>_____</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)
- | | |
|--------------------|---------------------|
| <u>LEADING AGE</u> | <u>21,541</u> |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | <u>21,541</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 66,241 Line 10-2
- (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. \$ 440,525
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? Yes 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? Yes Indicate the amount. \$ 18,908
- (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? Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CLA
- (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.