

		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: 0057935

Facility Name: Westwood Vlge Nrsg Rhb Ctr

Address: 2444 West Touhy Ave Chicago 60645
Number City Zip Code

County: Cook

Telephone Number: 773-274-7705 Fax # 773-274-6173

HFS ID Number:

Date of Initial License for Current Owners: 05/01/2023

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name: Mendel S Schneider Telephone Number: 847-933-1274

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

(Signed) See Accountant's Report Attached

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address) Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076

(Telephone) 847-933-1274 Fax # 847-933-1283

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 Westwood Vlge Nrsg Rhb Ctr # 0057935 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>89</u>	Intermediate (ICF)	<u>89</u>	<u>32,485</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</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			3,915	172	1,008	2,170	292	7,557	8
9	SNF/PED									9
10	ICF	5,425	25,572						30,997	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,425	25,572	3,915	172	1,008	2,170	292	38,554	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.85%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 05/01/2023

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/2023 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 26

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Westwood Vlge Nrsg Rhb Ctr # 0057935 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	387,848	77,982	40,365	506,195		506,195		506,195			1
2	Food Purchase		429,111		429,111		429,111	(1,103)	428,008			2
3	Housekeeping	216,632	79,337	56,134	352,103		352,103		352,103			3
4	Laundry	111,887	38,755		150,642		150,642		150,642			4
5	Heat and Other Utilities			104,614	104,614		104,614	2,630	107,244			5
6	Maintenance	105,804		146,973	252,777		252,777	4,481	257,258			6
7	Other (specify):*											7
8	TOTAL General Services	822,171	625,185	348,086	1,795,442		1,795,442	6,008	1,801,450			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	4,371,991	157,008	8,384	4,537,383		4,537,383		4,537,383			10
10a	Therapy											10a
11	Activities	143,144	4,875		148,019		148,019		148,019			11
12	Social Services	178,385		13,652	192,037		192,037		192,037			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,693,520	161,883	41,036	4,896,439		4,896,439		4,896,439			16
	C. General Administration											
17	Administrative	145,025		574,640	719,665		719,665	(574,640)	145,025			17
18	Directors Fees											18
19	Professional Services			76,319	76,319		76,319	93,498	169,817			19
20	Dues, Fees, Subscriptions & Promotions			96,396	96,396		96,396	(29,988)	66,408			20
21	Clerical & General Office Expenses	336,605	185,475	104,300	626,380		626,380	108,567	734,947			21
22	Employee Benefits & Payroll Taxes			755,064	755,064		755,064		755,064			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,655	2,655		2,655		2,655			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			324,527	324,527		324,527	754	325,281			26
27	Other (specify):* Allocated Benefits							20,175	20,175			27
28	TOTAL General Administration	481,630	185,475	1,933,901	2,601,006		2,601,006	(381,634)	2,219,372			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,997,321	972,543	2,323,023	9,292,887		9,292,887	(375,626)	8,917,261			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			47,130	47,130		47,130	464,765	511,895			30
31	Amortization of Pre-Op. & Org.							12,153	12,153			31
32	Interest							469,173	469,173			32
33	Real Estate Taxes			236,274	236,274		236,274		236,274			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(657,261)	2,739			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			410,849	410,849		410,849	(410,849)				36
37	TOTAL Ownership			1,354,253	1,354,253		1,354,253	(122,019)	1,232,234			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,233	466,590	601,823		601,823		601,823			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			711,917	711,917		711,917		711,917			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		135,233	1,178,507	1,313,740		1,313,740		1,313,740			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,997,321	1,107,776	4,855,783	11,960,880		11,960,880	(497,645)	11,463,235			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	(142,888)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,103)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(410,849)	36		24
25	Fund Raising, Advertising and Promotional	(16,648)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (571,488)		\$	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)	87,183		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 87,183		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (484,305)		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	\$ (13,340)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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48				48
49	Total	(13,340)		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	\$ 660,000	Westwood Village Property LLC	100.00%	\$	(660,000)	1
2	V	30	Depreciation		Westwood Village Property LLC		607,653	607,653	2
3	V	31	Amortization		Westwood Village Property LLC		12,153	12,153	3
4	V	32	Interest		Westwood Village Property LLC		469,173	469,173	4
5	V	21	Office		Westwood Village Property LLC		17,488	17,488	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			\$ 660,000			\$ 1,106,467	\$ * 446,467	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	\$ 574,640			\$	\$ (574,640)	15
16	V	21	Office				25,396	25,396	16
17	V	19	Professional Fees				93,498	93,498	17
18	V	5	Utilities				2,630	2,630	18
19	V	6	Repairs & Maintenance				4,481	4,481	19
20	V	34	Rent				2,739	2,739	20
21	V	21	Clerical Wages				65,683	65,683	21
22	V	27	Allocated benefits				20,175	20,175	22
23	V	26	Insurance				754	754	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			\$ 574,640			\$ 215,356	\$ * (359,284)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Westwood Vlge Nrsg Rhb Ctr								
ID#					0057935			
Report Period Beginning:					01/01/2025			
Ending:					12/31/2025			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee		Building Co.	Management
-Owners of companies must be listed instead of company names.					Ownership		Ownership	Co./Home Office
-Names of trust beneficiaries must be listed.					Percentage		Percentage	Ownership
First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage	Percentage
1	Jake	0	Mashiach	Chicago	IL	23.33000		1
2	Yechiel	0	Mashiach	Lincolnwood	IL	23.33000		2
3	Rhonda	0	Mashiach	Lincolnwood	IL	10.00000		3
4	Rita	0	Lipshitz	Skokie	IL	10.00000		4
5	Atied Associates, LLC	0	0	0	0	0.00000		5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000		6
7	Beneficiaries	0	0	0	0	0.00000		7
8	Rebecca	0	Rudolph	Evanston	IL	0.38469		8
9	Michael	0	Rudolph	Evanston	IL	0.38469		9
10	Zahava	0	Vales	Evanston	IL	0.38469		10
11	Raban	0	Vales	Evanston	IL	0.38469		11
12	Natan	0	Vales	Deerfield	IL	0.38469		12
13	Amidei	0	Vales	Deerfield	IL	0.38469		13
14	Cary	0	Silvers	Evanston	IL	0.38469		14
15	Jonathan	0	Silvers	Highland Park	IL	0.38469		15
16	Jacob	0	Silvers	Highland Park	IL	0.38469		16
17	Noam	0	Rothner	Teaneck	NJ	0.38469		17
18	Yonit	0	Rothner	Teaneck	NJ	0.38469		18
19	Hanna	0	Levine	Skokie	IL	0.38469		19
20	Nathan	0	Levine	Evanston	IL	0.38469		20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000		21
22	Beneficiaries	0	0	0	0	0.00000		22
23	Melisa	0	Rothner	Skokie	IL	1.25025		23
24	Daniel	0	Rothner	Teaneck	NJ	1.25025		24
25	William	0	Rothner	Skokie	IL	1.25025		25
26	Rachel	0	Rothner	Beachwood	OH	1.25025		26
27	0	0	0	0	0	0.00000		27
28	Daniel Rothner Accumu	0	0	0	0	0.00000		28
29	Beneficiaries	0	0	0	0	0.00000		29
30	Daniel	0	Rothner	Teaneck	NJ	1.66700		30
31	William Rothner Accumu	0	0	0	0	0.00000		31
32	Beneficiaries	0	0	0	0	0.00000		32
33	William	0	Rothner	Skokie	IL	1.66700		33
34	Melisa Rothner Accumu	0	0	0	0	0.00000		34
35	Beneficiaries	0	0	0	0	0.00000		35
36	Melisa	0	Rothner	Skokie	IL	1.66700		36
37	Rachel Rothner Accumu	0	0	0	0	0.00000		37
38	Rachel	0	Rothner	Beachwood	OH	1.66700		38
39	Adam Vales Accumulati	0	0	0	0	0.00000		39
40	Adam	0	Vales	Deerfield	IL	1.66700		40
41	Kathryn Vales Accumul	0	0	0	0	0.00000		41
42	kathryn	0	Vales	Highland park	IL	1.66700		42
43	Kimberly Vales Accumu	0	0	0	0	0.00000		43
44	Kimberly	0	Vales	Highland Park	IL	1.66700		44
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Facility Name & ID Number

Westwood Vlge Nrsg Rhb Ctr

0057935

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CEN	Joliet	Jade Financial Serv	Skokie, ILL	Mgmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis	Westwood Vil Prop	Chicago	Bldg Rental	2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION C	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATIO	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION C	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITA	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER L	Tucson				8
9	ELMWOOD NURSING & REHABILITATION	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER I	Crestwood	DEVON GABLES REHABILITATION CENTE	Tucson				10
11	KENSINGTON NURSING AND REHABILITA	Chicago	ST. JAMES WELLNESS REHAB & VILLAS L	Crete				11
12	ABBINGTON VILLAGE NURSING AND REH	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILIT	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHAB	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	wheaton Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION C	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION C	Rushville	RUSHVILLE NURSING REHABILITATION C	Rushville				20
21	NEIGHBORS REHABILITATION CENTER L	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER I	Champaign	PARK VILLA NURSING & REHABILITATIO	Palos Heights				22
23	Sheridan Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REH	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Tri State Village & Nursing Center	Chicago	UNIVERSITY REHABILITATION CENTER C	Urbana				25
26			PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27			BURBANK REHABILITATION CENTER LLC	Burbank				27
28			COUNTRYSIDE NURSING & REHABILITAT	Dolton				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									\$		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 Westwood Vlge Nrsg Rhb Ctr # 0057935 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Jade Financial Services LLC
Street Address 8707 Skokie Blvd
City / State / Zip Code Skokie, ILL 6077
Phone Number (847-213-1060
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	21	Office	Number of Beds	1,231	10	\$ 271,852	\$	115	\$ 25,396	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		115	93,498	2
3	5	Utilities	Number of Beds	1,231	10	28,149		115	2,630	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		115	4,481	4
5	34	Rent	Number of Beds	1,231	10	29,319		115	2,739	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	115	65,683	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		115	20,175	7
8	26	Insurance	Number of Beds	1,231	10	8,068		115	754	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					\$ 2,305,240	\$ 703,094		\$ 215,356	25

Facility Name & ID Number Westwood Vlge Nrsg Rhb Ctr # 0057935 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Huntington Bank		X	Mortgage			\$ 6,409,737	\$ 6,023,352			\$ 469,173	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 6,409,737	\$ 6,023,352			\$ 469,173	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,409,737	\$ 6,023,352			\$ 469,173	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2024 report.				\$	183,499	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.)				\$	204,767	2
3. Under or (over) accrual (line 2 minus line 1).				\$	21,268	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	215,006	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	236,274	7
Assessed Value from Real Estate Tax Bill: 2024 8						
Real Estate Tax Bill for Calendar Year: 2020 9						
2021 10						
2022 178,883 11						
2023 183,499 12						
2024 204,767 13						
Line 4: 204767 x 1.05				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 Westwood Vlge Nrsg Rhb Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0057935

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 FAX #: ()

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>10-25-427-035-0000</u>	<u>LTC Property</u>	\$ <u>187,066.82</u>	\$ <u>187,066.82</u>
2.	<u>10-25-427-010-0000</u>	<u>LTC Property</u>	\$ <u>17,700.43</u>	\$ <u>17,700.43</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>204,767.25</u></u>	\$ <u><u>204,767.25</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,250 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (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).

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

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

1. Total Amount Incurred: 60,764 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 12,153 4. Dates Incurred: 05/01/23

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2023	\$ 246,033	1
2					2
3	TOTALS			\$ 246,033	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	115		2023		\$ 5,011,793	\$	27.5	\$ 182,247	\$ 182,247	\$ 546,741
5										
6										
7										
8										
	Improvement Type**									
9	Jet Womens Bathroom from Toilets to Main Sewer Line			2023	21,700		15	1,447	1,447	4,341
10	Install 2 New Shut Off Valves,2 New Ejector Pumps,New Copper Pipe			2023	95,000		15	6,333	6,333	18,999
11	Repair 4 Inch Broken Pipe 7-8 Feer Underground Outside Bath			2023	17,800		15	1,187	1,187	3,561
12	New Sign			2023	15,000		15	1,000	1,000	3,000
13	Install 3 New faucets,Replace Portions of Main Sewer Line			2024	21,675		15	1,445	1,445	2,890
14	New Hot Water Heater			2024	22,746		15	1,516	1,516	3,032
15	Replaced Hot Water Tank			2024	8,106		15	540	540	1,080
16	Replace 3 Toilets			2024	3,750		15	250	250	500
17	Install 5 Commercial Faucets			2024	11,000		15	733	733	1,466
18	Replace Drains im 3 Comp Sink			2024	4,200		15	280	280	560
19	Replace Faulty Hot Surface Ignitor			2024	4,527		15	302	302	604
20	Replace Laundry & Kitchen Fan Coil Blowers & Motors			2024	9,063		15	604	604	1,208
21	Clean Coils & Motors for HVAC System in All Resident Rooms			2024	7,394		15	493	493	986
22	Deep Cleaning of Sewer Line on west Side of Building			2024	3,600		15	240	240	480
23	New Door Room 142			2025	4,409		15	294	294	294
24	Lower Level Kitchen Door			2025	3,840		15	256	256	256
25	Repair Roof, Apply Aluminum Roof Coating,Skylight Instal			2025	17,400		15	1,160	1,160	1,160
26	Exhaust Fan Replacement Rooms 124,151			2025	9,416		15	628	628	628
27	Install Sewer Pipe-Rear of Building			2025	42,000		15	2,800	2,800	2,800
28	Replace Damaged Injector Pump			2025	5,750		15	383	383	383
29	Replace 2 Inch Copper Pipes in Dishwasher & Sink			2025	7,600		15	507	507	507
30	Install Motor HVAC System-Rooms 131,132,128			2025	16,697		15	1,113	1,113	1,113
31	Jetting Main Sewer Line			2025	4,850		15	323	323	323
32	Replace Main Water Line			2025	5,493		15	366	366	366
33										
34										
35	Financial State Depreciation					654,783			(654,783)	
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)		\$ 5,374,809	\$ 654,783		\$ 206,447	\$ (448,336)	\$ 597,278	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	\$3,054,475	\$	\$305,448	\$305,448	10	\$618,035	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$3,054,475	\$	\$305,448	\$305,448		\$618,035	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)	\$8,675,317	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$654,783	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$511,895	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(142,888)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,215,313	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	Allocated from Jade				2,739			6
7	TOTAL				\$ 2,739			7

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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	39-3	hrs	\$		\$ 196,570	\$		\$ 196,570	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			49,435			49,435	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			220,585			220,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				49,123		49,123	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					86,110		86,110	12
13	Other (specify):									13
14	TOTAL			\$		\$ 466,590	\$ 135,233		\$ 601,823	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 349,007	\$ 947,606	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,964,985	2,964,985	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	571,091	571,091	7
8	Accounts Receivable (owners or related parties)	9,051	9,051	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,894,134	\$ 4,492,733	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		246,033	13
14	Buildings, at Historical Cost		5,011,793	14
15	Leasehold Improvements, at Historical Cost	378,016	378,016	15
16	Equipment, at Historical Cost	118,356	3,061,634	16
17	Accumulated Depreciation (book methods)	(81,169)	(1,701,577)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		60,764	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(32,407)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 415,203	\$ 7,024,256	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,309,337	\$ 11,516,989	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,772,137	\$ 1,772,137	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	338,997	338,997	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,753	12,753	31
32	Accrued Real Estate Taxes(Sch.IX-B)	215,006	215,006	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related	3,175,523	4,005,779	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,514,416	\$ 6,344,672	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,023,352	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)	\$	\$ 6,023,352	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,514,416	\$ 12,368,024	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,205,079)	\$ (851,035)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,309,337	\$ 11,516,989	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,022,781)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,022,781)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(182,298)	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)	\$ (182,298)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,205,079)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westwood Vlge Nrsg Rhb Ctr

0057935

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,778,582	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,778,582	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,778,582	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,795,442	31
32	Health Care	4,896,439	32
33	General Administration	2,601,006	33
	B. Capital Expense		
34	Ownership	1,354,253	34
	C. Ancillary Expense		
35	Special Cost Centers	601,823	35
36	Provider Participation Fee	711,917	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,960,880	40
41	Income before Income Taxes (line 30 minus line 40)**	(182,298)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (182,298)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,375,988.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,940,079.00	45
46	MMAI-Medicaid is the Primary Payer	973,561.00	46
47	MMAI-Medicare is the Primary Payer	117,900.00	47
48	Private Pay	250,382.00	48
49	Medicare Part A	1,688,804.00	49
50	Other-(specify) Medicare-B	290,426.00	50
51	Other-(specify) Insurance	141,442.00	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)	\$ 11,778,582	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	1,944	2,302	\$ 138,795	\$ 60.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,605	23,144	1,257,450	54.33	3
4	Licensed Practical Nurses	23,534	25,007	1,241,550	49.65	4
5	CNAs & Orderlies	61,200	66,909	1,720,756	25.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,719	1,925	43,334	22.51	9
10	Activity Assistants	4,457	5,172	99,810	19.30	10
11	Social Service Workers	4,979	5,723	178,385	31.17	11
12	Dietician					12
13	Food Service Supervisor	2,163	2,235	66,370	29.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,270	14,676	321,478	21.91	15
16	Dishwashers					16
17	Maintenance Workers	2,641	2,833	105,804	37.35	17
18	Housekeepers	10,236	10,904	216,632	19.87	18
19	Laundry	4,997	5,528	111,887	20.24	19
20	Administrator	1,992	2,080	145,025	69.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,136	7,828	336,605	43.00	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					31
32	Other Health Care(specify)					32
33	Other(specify) MDS	240	240	13,440	56.00	33
34	TOTAL (lines 1 - 33)	162,113	176,506	\$ 5,997,321 *	\$ 33.98	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	\$ 40,365	1-3	35
36	Medical Director	Monthly	19,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,384	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	Monthly	13,652	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 81,401		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 NumberWestwood Vlge Nrsg Rhb Ctr# 0057935Report Period Beginning:01/01/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Yvonne Edwards Thomas

Administrator

0

\$ 145,025

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 145,025

B. Administrative - Other

Description

Amount

Jade Financial-Mgmt Fees

\$ 574,640

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 574,640

C. Professional Services

Vendor/Payee

Type

Amount

Mendel Schneider CPA

Accounting

\$ 10,400

Sher LLP

Legal

5,100

Much Shelist

Legal

840

SLR LOC

Legal

2,657

Elizabeth Nash

Clinical Reimb

28,800

Guided Care

Case Mgmt

21,500

Stout

Appraisal

5,510

Personnel Planners

UC Tax Cons

1,512

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 76,319

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 64,784

Unemployment Compensation Insurance

23,372

FICA Taxes

440,314

Employee Health Insurance

226,594

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

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

\$ 755,064

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

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

40,953

Health Care Worker Background Check

642

(Indicate # of checks performed)

Patient Background Checks

2,050

Association Dues (total from pg 22, #4)

20,010

RADAR

6,408

Various

7,695

Less: Public Relations Expense

()

PAC and Lobbying payments

(13,340)

All non-allowable advertising

()

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

\$ 66,408

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Various

2,655

Entertainment Expense

()

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

\$ 2,655

* Attach copy of IMRF notifications

**See instructions.

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)	6,670
	6,670 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)	13,340
	13,340 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	20,010
	20,010 Total
- (5)

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

\$ 31,594 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.

\$ 711,917

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

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

No If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

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

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

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

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

d. Have vehicle usage logs been maintained?

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

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?

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (13)

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

No

Firm Name:
- (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.