

Facility Name & ID Number Zachary House# 0042275Report 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		Skilled (SNF)		-	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD		-	4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	-								11
12	SC									12
13	DD 16 OR LESS	<u>4,897</u>							<u>4,897</u>	13
14	TOTALS	<u>4,897</u>							<u>4,897</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 83.85%D. How many bed reserve days during this year were paid by the Department?
71 (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)NoneF. Does the facility maintain a daily midnight census? YesG. 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 12/16/96

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

YES ☐ Date 12/16/96 NO ☒

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

YES ☐ NO ☒ If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

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Facility Name & ID Number Zachary House # 0042275 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
1	Dietary	31,791	8,569		40,360	(78)	40,282		40,282		1
2	Food Purchase		75,686		75,686		75,686		75,686		2
3	Housekeeping	19,675	1,797		21,472		21,472		21,472		3
4	Laundry		24		24		24		24		4
5	Heat and Other Utilities			22,165	22,165		22,165		22,165		5
6	Maintenance		4,210	21,394	25,604		25,604		25,604		6
7	Other (specify):*										7
8	TOTAL General Services	51,466	90,286	43,559	185,311	(78)	185,233		185,233		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	254,572	2,635	10,032	267,239		267,239	1,662	268,901		10
10a	Therapy										10a
11	Activities			1,275	1,275		1,275		1,275		11
12	Social Services		454	1,155	1,609		1,609		1,609		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	254,572	3,089	12,462	270,123		270,123	1,662	271,785		16
	C. General Administration										
17	Administrative							65,811	65,811		17
18	Directors Fees										18
19	Professional Services			69,585	69,585	(125)	69,460		69,460		19
20	Dues, Fees, Subscriptions & Promotions			304	304	125	429		429		20
21	Clerical & General Office Expenses			10,810	10,810	(1,275)	9,535	19,578	29,113		21
22	Employee Benefits & Payroll Taxes			32,213	32,213	1,353	33,566	10,066	43,632		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							74,837	74,837		26
27	Other (specify):*										27
28	TOTAL General Administration			112,912	112,912	78	112,990	170,292	283,282		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	306,038	93,375	168,933	568,346		568,346	171,954	740,300		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.

STATE OF ILLINOIS

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Facility Name & ID Number Zachary House

#0042275

Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			1,755	1,755		1,755	17,353	19,108			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			24,292	24,292		24,292	855	25,147			33
34	Rent-Facility & Grounds			156,000	156,000		156,000	(156,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			182,047	182,047		182,047	(137,792)	44,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,363		2,363		2,363		2,363			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,466	61,466		61,466		61,466			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,363	61,466	63,829		63,829		63,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	306,038	95,738	412,446	814,222		814,222	34,162	848,384			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		2.2		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	17,353	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees		13		27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	279			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,632		\$	30

BHF USE ONLY							
48		49		50		51	

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)	16,530		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 16,530		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 34,162		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.		x	\$		38
39	Physician Care		x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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
Byrn T. Witt	50.00%	Meadows	Rolling Meadows			
Barbara S. Witt	50.00%	Meadows	Rolling Meadows			

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V	17 Administration		Meadows		65,811	65,811	3
4	V	10 Behavior Dev'l		Meadows		1,662	1,662	4
5	V	21 Personnel, Accounting, Etc.		Meadows		12,537	12,537	5
6	V	21 General Office Supplies		Meadows		2,540	2,540	6
7	V	21 General Office Other		Meadows		4,501	4,501	7
8	V	22 Employee Benefits		Meadows		10,066	10,066	8
9	V	21 Administrative Overhead	279	Meadows			(279)	9
10	V	34 Facility Rent	156,000	Byrn T. Witt & Barbara S. Witt	100.00%		(156,000)	10
11	V							11
12	V	26 Insurance		Meadows		74,837	74,837	12
13	V	33 Real Estate Tax	24,292	Byrn T. Witt & Barbara S. Witt	100.00%	25,147	855	13
14	Total		\$ 180571			\$ 197,101	\$ * 16,530	14

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

Ownership Listing-1

ID# 0042275

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

Operator/Licensee	Building Co.	Co./Home Office
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100		

Place of Residence

Percentage	Percentage	Percentage
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1	Byrn	T	Witt	Arlington Heights IL	50.00000			1
2	Barbara	S	Witt	Arlington Heights IL	50.00000			2
3								3
4								4
5								5
6								6
7								7
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71								71
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73								73
74								74
75								75

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 Zachary House

0042275

Report Period Beginning:

01/01/2025

Ending: 12/31/2025

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 ☐

Name of Related Organization

Meadows Sheltered Care, Inc.

Street Address

3250 South Plum Grove Road

City / State / Zip Code

Rolling Meadows, IL 60008

Phone Number

(847) 397-0055

Fax Number

(847) 397-0477

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

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	21.1	Office	Direct Cost	7,248	2	194,163	194,163	468	12,537	2
3	17.1	Administration	Direct Cost	2,054	2	162,469	162,469	832	65,811	3
4	10.1	Behavior Dev'l	Direct Cost	4,632	2	186,634	186,634	41	1,662	4
5	21.2	Office Supplies	Expenses	3,159,986	2	15,795		508,184	2,540	5
6	21.3	Office Other	Expenses	3,159,986	2	27,987		508,184	4,501	6
7	22.3	Employee Benefits	Salary	3,090,005	2	388,751		80,010	10,066	7
8	26.3	Insurance	Expenses	3,159,986	2	465,351		508,184	74,837	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					\$ 1,441,150	\$ 543,266		\$ 171,954	25

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number **Zachary House**# **0042275** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	\$	23,437	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.)			\$	24,292	2
3. Under or (over) accrual (line 2 minus line 1).			\$	855	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	24,292	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.			\$	25,147	7
Assessed Value from Real Estate Tax Bill:	2024	76,970	8		
Real Estate Tax Bill for Calendar Year:	2020	35,186	9		
	2021	35,740	10		
	2022	20,303	11		
	2023	23,437	12		
	2024	24,292	13		
Accrual based on current year assessment.					

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

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 Zachary House COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0042275
 CONTACT PERSON REGARDING THIS REPORT Doreatha Norris
 TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-25-301-043-0000</u>		\$ 24,292.00	\$ 24,292.00
2. _____		\$ _____	\$ _____
3. _____		\$ _____	\$ _____
4. _____		\$ _____	\$ _____
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u>24,292.00</u>	\$ <u>24,292.00</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 provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

4,680

B. General Construction Type:

Exterior

Brick & Siding

Frame

Wood

Number of Stories

One

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).

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒

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

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
	1 ICF/DD 16	52,695	1995	\$ 145,000	1
	2				2
	3 TOTALS	52,695		\$ 145,000	3

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1996	1996	\$ 509,864	\$	39	\$ 13,073	\$ 13,073	\$ 379,117	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1997	16,650		39	427	427	12,220	9
10	Time Clock Sytem			1999			5				10
11	Floor Covering			2002	2,985		7			2,985	11
12	Wall Covering			2002	672		7			672	12
13	Bathroom cabinetry			2010			7				13
14	Driveway installation			2010			15				14
15	Kitchen countertop and cabinetry			2014	3,195		7			3,195	15
16	New building roof			2014	16,970	591	15	1,131	540	12,630	16
17	New flooring inside house			2014	6,183	215	15	412	197	4,544	17
18	New flooring inside house			2015	28,468	949	15	1,898	949	20,873	18
19	Window blinds throughout building			2015	2,741		7			2,741	19
20	Driveway back area			2016	4,410		15	294	294	2,670	20
21	Central sprinkler system life safety			2016	6,991		15	466	466	4,349	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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	\$ 35,246	\$	\$ 1,407	\$ 1,407	5	\$ 35,246	71
72	Current Year Purchases					5		72
73	Fully Depreciated Assets	7,306					7,306	73
74								74
75	TOTALS	\$ 42,552	\$	\$ 1,407	\$ 1,407		\$ 42,552	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	Patient Transport	2016 Ford Van	2016	42,455				5	42,455	79
80	TOTALS			\$ 42,455	\$	\$			\$ 42,455	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)	\$ 829,136	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,755	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,108	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,353	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 531,003	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES
☒ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy: ☐ YES ☒ NO Terms: *

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

15. Is Movable equipment rental included in building rental?

☐ YES
☒ NO

16. Rental Amount for movable equipment: \$

Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12. /2026 \$

13. /2027 \$

14. /2028 \$

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

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

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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. <u>CLASSROOM PORTION:</u> IN-HOUSE PROGRAM ☐ IN OTHER FACILITY ☐ COMMUNITY COLLEGE ☐ HOURS PER CNA _____	3. <u>CLINICAL PORTION:</u> IN-HOUSE PROGRAM ☐ IN OTHER FACILITY ☐ HOURS PER CNA _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts				2,363		2,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$		\$	\$ 2,363		\$ 2,363	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.

STATE OF ILLINOIS

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Facility Name & ID Number Zachary House

0042275

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025

(last day of reporting year)

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	\$ 1,017,206	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	21,922		3
4	Supply Inventory (priced at FIFO)	865		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,039,993	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	60,265		15
16	Equipment, at Historical Cost	71,036		16
17	Accumulated Depreciation (book methods)	(124,211)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,090	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,047,083	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,331	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 30,331	\$	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)	\$ 30,331	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,016,752	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,047,083	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,176,038	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5	Rounding	(1)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,176,037	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	260,792	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	(420,077)	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)	\$ (159,285)	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)	\$ 1,016,752	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Zachary House

0042275

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	\$ 1,074,960	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,074,960	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***	54	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous		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)	\$ 1,075,014	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	185,311	31
32	Health Care	270,123	32
33	General Administration	112,912	33
B. Capital Expense			
34	Ownership	182,047	34
C. Ancillary Expense			
35	Special Cost Centers	2,363	35
36	Provider Participation Fee	61,466	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 814,222	40
41	Income before Income Taxes (line 30 minus line 40)**	260,792	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 260,792	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,061,761	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	-	45
46	MMAI-Medicaid is the Primary Payer	-	46
47	MMAI-Medicare is the Primary Payer	-	47
48	Private Pay	-	48
49	Medicare Part A	-	49
50	Other-(specify) State of IL day program workshop	13,199	50
51	Other-(specify)	-	51
52	Other-(specify)	-	52
53	Other-(specify)	-	53
54	Other-(specify) Rounding	-	54
55	Other-(specify)	-	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,074,960	56

Facility Name & ID Number Zachary House

STATE OF ILLINOIS
0042275

Report Period Beginning: 01/01/2025 Ending: 12/31/2025 Page 20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,805	1,880	31,791	16.91	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,090	1,090	19,675	18.05	18
19	Laundry					19
20	Administrator	832	832	65,811	79.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	468	468	12,537	26.79	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)	10,623	11,394	254,571	22.34	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Behavior Dev'l</u>	41	41	1,662	40.29	33
34	TOTAL (lines 1 - 33)	14,859	15,705	\$ 386,048 *	\$ 24.58	34

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

** See instructions.

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	29	\$ 1,275	1.3	35
36	Medical Director				36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant	322	8,638	10.3	38
39	Pharmacist Consultant	23	1,394	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant				44
45	Social Service Consultant			12.3	45
46	Other(specify) <u>Psychiatrist</u>	0.25	75	12.3	46
47					47
48				12.3	48
49	TOTAL (lines 35 - 48)	374	\$ 11,382		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

Facility Name & ID Number Zachary House

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance		1,582	Advertising: Employee Recruitment	
				FICA Taxes		22,971	Health Care Worker Background Check	125
				Employee Health Insurance		7,460	(Indicate # of checks performed <u>4</u>)	
				Employee Meals		1,353	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	
				Staff Appreciation		200	License and Dues	304
				Employee Life/Disability				
				Dental Insurance				
				Allocation of Employee Benefits		10,066		
				Employee Physicals			Less: Public Relations Expense	()
				Rounding		1	PAC and Lobbying payments	()
							All non-allowable advertising	()
See Schedule								
TOTAL (agree to Schedule V, line 17, col. 1)			\$	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)							\$ 429	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
See Schedule								
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL			TOTAL	
(For legal fee disclosure, see page 39 of instructions)			69,585					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Zachary House

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

Other, please specify

10

Other, please specify

- 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.

Other, please specify

10

Other, please specify _____

- Total

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

Other, please specify

1

Other, please sp

100

100

100

 Total

- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 253 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. \$ 61,466
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. \$ 1,353 Has any meal income been offset against related costs? No Indicate the amount. \$ -

- (12) Travel and Transportation

- a. Are there costs included for out-of-state travel? **No**

If YES, attach a complete explanation.

- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$

- c. What percent of all travel expense relates to transportation of nurses and patients? 100%

- 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? N/A

- | | |
|---|--------|
| g. Does the facility transport residents to and from day training? | Yes |
| Indicate the amount of income earned from providing such transportation during this reporting period. | |
| \$ | 13,199 |

- (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.