

		FOR BHF USE					

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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: 0045443

Facility Name: Addolorata Villa

Address: 555 McHenry Road Wheeling 60090

County: Cook

Telephone Number: 847-251-5801 Fax #: 847-215-5805

HFS ID Number:

Date of Initial License for Current Owners: 11/27/1996

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Matt Larsh, Singing Director Telephone Number: 630-368-3666
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/1/2024 to 06/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Robert Rosenberger

(Title) CFO

Paid Preparer

(Print Name and Title) Matthew Larsh Signing Director

(Firm Name & Address) CLA (CliftonLarsonAllen LLP) 833 West Lincoln Hwy, Suite 210W, Schererville, IN 46375

(Telephone) 630-368-3666 Fax #: 219-864-0055

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

Facility Name & ID Number Addolorata Villa # 0045443 Report Period Beginning: 07/1/2024 Ending: 06/30/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>82</u>	<u>31,478</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>10</u>	Intermediate (ICF)	<u>10</u>	<u>3,650</u>	3
4		Intermediate/DD			4
5	<u>43</u>	Sheltered Care (SC)	<u>43</u>	<u>15,695</u>	5
6		ICF/DD 16 or Less			6
7	<u>141</u>	TOTALS	<u>135</u>	<u>50,823</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	3,092	6,228	967		10,336	1,783	712	23,118	8
9	SNF/PED									9
10	ICF	183	365	182		1,650			2,380	10
11	ICF/DD									11
12	SC					4,646			4,646	12
13	DD 16 OR LESS									13
14	TOTALS	3,275	6,593	1,149		16,632	1,783	712	30,144	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 59.31%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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 11/27/1996

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/27/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 82

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2025 Fiscal Year: 06/30/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		Addolorata Villa		STATE OF ILLINOIS		# 0045443		Report Period Beginning:		07/1/2024		Ending:		Page 3		06/30/2025	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)																	
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY							
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10						
	A. General Services																
1	Dietary		34,500	1,053,044	1,087,544		1,087,544	11,149	1,098,693								1
2	Food Purchase		333,579		333,579		333,579	0	333,579								2
3	Housekeeping	343,280	48,962	1,003	393,245		393,245	0	393,245								3
4	Laundry		8,994	220	9,214	0	9,214	0	9,214								4
5	Heat and Other Utilities			281,403	281,403		281,403	0	281,403								5
6	Maintenance	161,402	90,213	354,492	606,107		606,107	30,343	636,450								6
7	Other (specify):*				0		0	0	0								7
8	TOTAL General Services	504,682	516,248	1,690,162	2,711,092	0	2,711,092	41,492	2,752,584								8
	B. Health Care and Programs																
9	Medical Director			24,000	24,000		24,000	0	24,000								9
10	Nursing and Medical Records	4,422,725	251,516	841,453	5,515,694		5,515,694	0	5,515,694								10
10a	Therapy				0		0	0	0								10a
11	Activities	134,834	500	19,423	154,757		154,757	52,163	206,920								11
12	Social Services	114,774	2,288	25,486	142,548		142,548	(2,818)	139,730								12
13	CNA Training				0		0	0	0								13
14	Program Transportation	5,960	15		5,975		5,975	0	5,975								14
15	Other (specify):*				0		0	0	0								15
16	TOTAL Health Care and Programs	4,678,293	254,319	910,362	5,842,974	0	5,842,974	49,345	5,892,319								16
	C. General Administration																
17	Administrative	289,601		1,076,523	1,366,124		1,366,124	(946,197)	419,927								17
18	Directors Fees				0		0	0	0								18
19	Professional Services			44,583	44,583		44,583	248,217	292,800								19
20	Dues, Fees, Subscriptions & Promotions			33,164	33,164		33,164	5,722	38,886								20
21	Clerical & General Office Expenses	262,289	9,370	237,563	509,222		509,222	405,022	914,244								21
22	Employee Benefits & Payroll Taxes			1,704,162	1,704,162		1,704,162	174,323	1,878,485								22
23	Inservice Training & Education				0		0	0	0								23
24	Travel and Seminar			9,900	9,900		9,900	20,612	30,512								24
25	Other Admin. Staff Transportation			17,890	17,890		17,890	0	17,890								25
26	Insurance-Prop.Liab.Malpractice			218,752	218,752		218,752	13,218	231,970								26
27	Other (specify):*				0		0	0	0								27
28	TOTAL General Administration	551,890	9,370	3,342,537	3,903,797	0	3,903,797	(79,083)	3,824,714								28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,734,865	779,937	5,943,061	12,457,863	0	12,457,863	11,754	12,469,617								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			518,623	518,623		518,623	7,300	525,923			30
31	Amortization of Pre-Op. & Org.			19,350	19,350		19,350	0	19,350			31
32	Interest			259,376	259,376		259,376	(281)	259,095			32
33	Real Estate Taxes				0		0	1,457	1,457			33
34	Rent-Facility & Grounds				0		0	12,925	12,925			34
35	Rent-Equipment & Vehicles			13,990	13,990		13,990	(10,570)	3,420			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			811,339	811,339	0	811,339	10,831	822,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		110,307	666,216	776,523		776,523	0	776,523			39
40	Barber and Beauty Shops			16,223	16,223		16,223	(16,223)	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			428,218	428,218		428,218	0	428,218			42
43	Other (specify):* Marketing, AL/IL	4,195,964	14,267	4,708,734	8,918,965		8,918,965	(8,918,965)	0			43
44	TOTAL Special Cost Centers	4,195,964	124,574	5,819,391	10,139,929	0	10,139,929	(8,935,188)	1,204,741			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,930,829	904,511	12,573,791	23,409,131	0	23,409,131	(8,912,603)	14,496,528			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	(15,460)	1		4
5	Telephone, TV & Radio in Resident Rooms	(52,841)	21		5
6	Rented Facility Space	(1,548)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(281)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,208)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(633)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(38,987)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,109)	21		24
25	Fund Raising, Advertising and Promotional	(518,129)	43		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 PG5A	(9,287,327)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,941,523)		\$ 0	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,028,920	VII - B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,028,920		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (8,912,603)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Barber and Beauty	(16,223)	40	4
5	Other Income- Enrichment	(2,818)	12	5
6	AL/IL - Other	(4,490,711)	43	6
7	AL/IL - Salaries	(3,910,125)	43	7
8				8
9	Other Income- Facility	(34)	6	9
10	Insurance Settlement	(5,919)	26	10
11				11
12				12
13				13
14	Home Office AL/IL Expenses			14
15	Dietary	(30,491)	1	15
16	Maintenance	(42,320)	6	16
17	Activities	(103,084)	11	17
18	Administrative	(71,715)	17	18
19	Professional Fees	(136,587)	19	19
20	Dues & Subscriptions	(3,149)	20	20
21	A&G	(288,234)	21	21
22	A&G Benefits	(118,805)	22	22
23	Seminars and Travel	(11,343)	24	23
24	Insurance	(10,530)	26	24
25	RE Taxes	(8,007)	33	25
26	Rental Expense	(15,281)	34	26
27	Equipment Rental	(12,275)	35	27
28	Depreciation	(9,676)	30	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,287,327)		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership		Franciscan Village	Lemont, IL	Franciscan Sisters of C	Lemont, IL	Religious Cong.
		Mt. Alverna Village/ Ancora	Parma, OH	Franciscan Sisters Chi	Lemont, IL	Corp. Management
		St. Joseph Village	Chicago, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living
		Village at Victory Lakes	Lindenhurst, IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.
		University Place	West Lafayette, IN	St. Jude House	Crown Point, IN	Dom. Viol. Shelter
				Madonna Foundation	Lemont, IL	HS Foundation
				Village at Mercy Creel	Normal, IL	Ind. & Asst. Living

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

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 1,076,523			\$	\$ (1,076,523)	15
16	V	1	Dietary-Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	57,100	57,100	16
17	V	6	Maintenance - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	55,632	55,632	17
18	V	6	Maintenance - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	18,613	18,613	18
19	V	11	Activities - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	155,247	155,247	19
20	V	17	Administrative - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	202,041	202,041	20
21	V	19	Professional Fees		Franciscan Sisters of Chicago Service Corporation	100.00%	384,804	384,804	21
22	V	21	Clerical - Salary		Franciscan Sisters of Chicago Service Corporation	100.00%	656,695	656,695	22
23	V	21	Clerical - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	155,339	155,339	23
24	V	22	Employee Benefits		Franciscan Sisters of Chicago Service Corporation	100.00%	293,128	293,128	24
25	V	24	Seminar and Travel		Franciscan Sisters of Chicago Service Corporation	100.00%	31,955	31,955	25
26	V	26	Professional Fees		Franciscan Sisters of Chicago Service Corporation	100.00%	29,667	29,667	26
27	V	30	Depreciation		Franciscan Sisters of Chicago Service Corporation	100.00%	16,976	16,976	27
28	V	33	Real Estate Taxes		Franciscan Sisters of Chicago Service Corporation	100.00%	9,464	9,464	28
29	V	34	Lease/Rent - Building		Franciscan Sisters of Chicago Service Corporation	100.00%	28,206	28,206	29
30	V	35	Lease/Rent - Equipment		Franciscan Sisters of Chicago Service Corporation	100.00%	1,705	1,705	30
31	V	20	Dues & Subscriptions		Franciscan Sisters of Chicago Service Corporation	100.00%	8,871	8,871	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,076,523			\$ 2,105,443	\$ * 1,028,920	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 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								1
2								2
3								3
4			Franciscan Village	Lemont, IL	Franciscan Sisters of C	Lemont, IL	Religious Cong.	4
5			Mt. Alverna Village/ Ancora	Parma, OH	Franciscan Sisters Chi	Lemont, IL	Corp. Management	5
6			St. Joseph Village	Chicago, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living	6
7			Village at Victory Lakes	Lindenhurst, IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.	7
8			University Place	West Lafayette, IN	St. Jude House	Crown Point, IN	Dom. Viol. Shelter	8
9					Madonna Foundation	Lemont, IL	HS Foundation	9
10					Village at Mercy Cree	Normal, IL	Ind. & Asst. Living	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 6/30/2025

Fax Number

1	2	3	4	5	6	7	8	9	
Schedule V 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

Ending: 6/30/2025

()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary-Salaries	Expense	146,728,265	10	\$ 382,592	\$ 382,592	21,898,558	\$ 57,100	1
2	6	Maintenance-Salaries	Expense	146,728,265	10	372,756	372,756	21,898,558	55,632	2
3	6	Maintenance-Other	Expense	146,728,265	10	124,716		21,898,558	18,613	3
4	11	Activities-Salary	Expense	146,728,265	10	1,040,211	1,040,211	21,898,558	155,247	4
5	17	Administrative - Salary	Expense	146,728,265	10	1,353,747	1,353,747	21,898,558	202,041	5
6	19	Professional Fees	Expense	146,728,265	10	2,578,323		21,898,558	384,804	6
7	21	Clerical - Salary	Expense	146,728,265	10	4,400,097	4,400,097	21,898,558	656,695	7
8	21	Clerical - Other	Expense	146,728,265	10	1,040,830		21,898,558	155,339	8
9	22	Employee Benefits	Expense	146,728,265	10	1,964,064		21,898,558	293,128	9
10	24	Seminar and Travel	Expense	146,728,265	10	214,111		21,898,558	31,955	10
11	26	Professional Fees	Expense	146,728,265	10	198,778		21,898,558	29,667	11
12	30	Depreciation	Expense	146,728,265	10	113,743		21,898,558	16,976	12
13	33	Real Estate Taxes	Expense	146,728,265	10	63,411		21,898,558	9,464	13
14	34	Lease/Rent - Building	Expense	146,728,265	10	188,991		21,898,558	28,206	14
15	35	Lease/Rent - Equipment	Expense	146,728,265	10	11,424		21,898,558	1,705	15
16	20	Dues & Subscriptions	Expense	146,728,265	10	59,436		21,898,558	8,871	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 14,107,230	\$ 7,549,403		\$ 2,105,443	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Illinios Finance Authority		X	Refinanced Debt	Varies	06/28/2017	\$ 4,245,120	\$ 3,557,750	05/15/2047	4.8600	\$ 182,656	1	
2	Illinios Finance Authority		X	Refinanced Debt	Varies	10/14/2021	4,185,852	4,071,263	05/15/2050	4.9900	89,316	2	
3	Illinios Finance Authority		X	Refinanced Debt	Varies	05/15/2023	9,379,260	9,243,500	05/15/2047	2.8200	335,967	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 17,810,232	\$ 16,872,513			\$ 607,939	9	
	B. Non-Facility Related*												
10	Interest Income										(281)	10	
11	Alloc. Non-Allowable AI/IL										(343,823)	11	
12	Allocation variance										(4,740)	12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ (348,844)	14	
15	TOTALS (line 9+line14)						\$ 17,810,232	\$ 16,872,513			\$ 259,095	15	

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

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

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

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

FACILITY NAME	Addolorata Villa	COUNTY	Cook
---------------	------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT Matthew Larsh, Signing Director

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,613 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Independent Living - 80,036 Square Feet (100 Units)
Assisted Living - 59,584 Square Feet (65 Units)
Outpatient Therapy - 2, 332 Square Feet

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1996	\$ 644,127	1
2	Aooc. - Convent			28,094	2
3	TOTALS			\$ 672,221	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	135				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1996		5,181,017					9
10	Various		1997		571,578					10
11	Various		1998		179,798					11
12	Various		1999		301,948					12
13	Various		2000		2,510,370					13
14	Various		2001		81,111					14
15	Various		2002		118,623					15
16	Various		2003		50,998					16
17	Various		2004		534					17
18	Various		2005		22,055					18
19	Various		2006		59,090					19
20	Various		2007		194,257					20
21	Various		2008		19,504					21
22	Various		2009		22,823					22
23	Various		2010		69,766					23
24	Various		2011		158,756					24
25	Various		2012		125,020					25
26	Various		2013		273,684					26
27	Various		2014		389,969					27
28	Various		2015		45,218					28
29	Various		2016		23,804					29
30	Various		2017		147,950					30
31	Various		2018		45,646					31
32	Various		2019		103,072					32
33	Various		2020		40,132					33
34	Various		2021		23,282					34
35	Emergency phone system pmt 2 of 2 - throughout whole facility		2022		3,029					35
36	Ciscor Emergency phone contract - throughout whole facility		2022		2,841					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning:

07/1/2024

Ending:

06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Zentel Tech - Heat Pump - (Total cost: 10851)	2022	\$ 3,466	\$		\$	\$	\$	37
38	Taylor Plumbing: Shower Remodel-Nursing Home Resident Room	2022	16,420						38
39	Zentel Tech Heat Pump - (Total cost: 12456)	2023	3,978						39
40	Tom Callahan Plumbing - Hot Water Heater - (Total cost: 40500)	2023	12,935						40
41	Anagnos Door Co - fire shutter barrel - (Total cost: 4084)	2023	1,304						41
42	Otis Elevator - optiguard on elevator - (Total cost: 6910.79)	2023	2,207						42
43	Wet Solutions-Water treatment syst. Sheltered / Intermediate Car	2023	11,991						43
44	Zentel Tech - Chiller Replacement - (Total cost: 167174)	2023	53,393						44
45	Zentel Tech - Cooling Tower Spray Pump - (Total cost: 5500)	2023	1,757						45
46	DMH Enterprises Chapel Camera&Controller-(TC: 11519)	2023	3,679						46
47	Taylor Plumbing - Shower Install - (Total cost: 6790)	2023	6,790						47
48	DHM Enterprises WirelessMicrophoneSystem - (TC: 6916)	2024	2,209						48
49	Direct Supply - Nurse Call System - (Total cost: 139110)	2024	139,110						49
50	Hering Signs - Interior ADA Signs - (Total cost: 2554.58)	2024	2,555						50
51									51
52	Fiscal Year Additions: 2024-2025								52
53	Supreme Mansory - Brick Wall Repair(7600)	2024	2,424						53
54	Synergy Construction Group(7800)	2024	2,488						54
55	Synergy Construction Group(10587)	2024	3,377						55
56	Synergy Construction Group(1100)	2024	351						56
57	Synergy Construction Group(41640)	2024	13,283						57
58	Synergy Construction Group(47494.61)	2024	15,151						58
59	Zentel PTAC Unit(4489)	2025	1,432						59
60	Zentel Tech PTAC Replace(888)	2024	283						60
61	Direct Supply - Cord Mgmt Rolling Stand(367.99)	2024	368						61
62	Direct Supply TouchS Vital Monitor SNF(18843.72)	2025	18,844						62
63	Marpro Remodeling-Refng ktchn/bath 144(1520)	2024	485						63
64	Marpo Remodeling - Kitchen Cabinets(2500)	2024	798						64
65	Synergy Construction Group(47136)	2024	15,036						65
66	Continental Elec- Wiring Outlets Isnt(23956.55)	2024	7,642						66
67	Allied Universal Tech(11130.13)	2024	3,551						67
68	Synergy Construction Group(2000)	2024	638						68
69	Nexus Gate Hardware Per Code(3780)	2024	1,206						69
70	TOTAL (lines 4 thru 69)		\$ 11,115,026	\$ 0		\$ 0	\$ 0	\$ 0	70

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

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning:

07/1/2024

Ending:

06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,115,026	\$ 0		\$ 0	\$	\$ 0	1
2	Synergy Construction Group(31163)	2024	9,941						2
3	Synergy Construction Group(7445)	2024	2,375						3
4	Synergy Construction Group(67953.06)	2024	21,677						4
5	OTIS Elevator Operator Board & Upgrades(10385.71)	2024	3,313						5
6	AffiliatedCustServInc FireAlarm System(40589)	2025	12,948						6
7	Synergy Construction Group(18375)	2024	5,862						7
8	HD Supply - Lighting Fxtures(316.08)	2024	101						8
9	Zentel Tech - PTAC(4413)	2024	1,408						9
10	Zentel Tech - heat pump(5478)	2024	1,747						10
11	Zentel 1 Ton Heat Pump(10850)	2025	3,461						11
12	Zentel Heat Pump(11532)	2025	3,679						12
13	Direct Supply(418530.81)	2024	418,531						13
14	Blue Wire Communications(3509.4)	2024	1,119						14
15	Blue Wire Communications (v0000498)(8380)	2024	2,673						15
16	McCloud Aquatics Pond Pump(6869.66)	2025	2,191						16
17	OTIS Oump + Motor Replacement(22605.72)	2025	7,211						17
18	NexusCommTech-Delayed Agress Gate-Code(6205)	2024	1,979						18
19	Continental GFCI Outlet & EM light(4510.31)	2024	1,439						19
20	Metropolitan Sprinkler Head Replacement(5000)	2025	1,595						20
21	Metropolitan Sprinkler System Head(32687)	2025	10,427						21
22	Painting by Joe - Painting(1275)	2025	1,275						22
23	Painting by Joe - Painting(1275)	2025	1,275						23
24	Marco Molina - Paint(2850)	2025	2,850						24
25	Marco Molina - Paint(1550)	2025	1,550						25
26	Marco Molina - Paint(1450)	2025	1,450						26
27	Marco Molina - Paint(1600)	2025	1,600						27
28	Marco Molina - Paint(1350)	2025	1,350						28
29	Marco Molina - Paint(1400)	2025	1,400						29
30	Painting by Joe - Painting(725)	2025	725						30
31	Capital Labor(172)	2025	172						31
32	Capital Labor(172)	2025	172						32
33	CCG Group Inc - Concrete Sidewalk(2500)	2024	798						33
34	TOTAL (lines 1 thru 33)		\$ 11,643,321	\$ 0		\$ 0	\$ 0	\$ 0	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$11,643,321	\$0		\$0	\$	\$0	1
2	CCG Group - Sidewalk ADA Inserts(3350)	2024	1,069						2
3	CCG Group - Sidewalk(87920)	2024	28,046						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	Depreciation			518,623		518,623		9,421,340	23
24									24
25	Alloc - FSCSC (Page 6A)					16,976	16,976		25
26	Non-Allowable HO Allocation					(9,676)	(9,676)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$11,672,436	\$518,623		\$525,923	\$7,300	\$9,421,340	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$3,323,154	\$	\$	\$0		\$	71
72	Current Year Purchases	88,291			0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$3,411,445	\$0	\$0	\$0		\$0	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2010	\$54,645	\$	\$	\$0		\$	76
77	Facility	Dodge Ram Pickup Truck	2010	2,857			0			77
78	Facility	Bus(TC=120,107)	2014	25,804			0			78
79	Facility	Ford F-150(TC = 53,278)	2022	20,231			0			79
80	TOTALS			\$103,537	\$0	\$0	\$0		\$0	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)	\$15,859,639	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$518,623	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$525,923	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$7,300	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,421,340	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Assests - PY Total	\$46,349,319	\$	\$	86
87	Non-Care Assests - CY	3,346,030			87
88					88
89					89
90	Depreciation		687,477	19,075,065	90
91	TOTALS	\$49,695,349	\$687,477	\$19,075,065	91

G. Construction-in-Progress

	Description	Cost	
92	SNF Renovation	\$2,291,605	92
93			93
94			94
95		\$2,291,605	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	Alloc - FSCSC				12,925			6
7	TOTAL				\$ 12,925			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: \$ 13,990 Description: Equipment Rental, less IL/AL Allocations
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		\$
13.		\$
14.		\$

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. 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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (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	\$	2,928	\$ 226,154	\$	2,928	\$ 226,154	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		922	71,245		922	71,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		3,540	273,487	500	3,540	273,987	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				100,305		100,305	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Senior Rehab</u>	39-3				27,820			27,820	12
13	Other (specify): <u>Lab/Radiology/Other</u>	39-3 / 2				67,510	9,502		77,012	13
14	TOTAL			\$	7,390	\$ 666,216	\$ 110,307	7,390	\$ 776,523	14

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

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,698	\$	1
2	Cash-Patient Deposits	7,368		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (160,276))	904,002		3
4	Supply Inventory (priced at)	209,460		4
5	Short-Term Investments			5
6	Prepaid Insurance	218,338		6
7	Other Prepaid Expenses	115,842		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,460,708	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	62,266		12
13	Land	1,941,270		13
14	Buildings, at Historical Cost	33,752,625		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,190,222		16
17	Accumulated Depreciation (book methods)	(25,941,890)		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):	2,358,146		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,362,639	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,823,347	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 591,215	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	683,256		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	279,619		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,514		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	0		33
34	Deferred Compensation	13,978		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other - Accrued Exp	252,231		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,823,813	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,823,813	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 16,999,534	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,823,347	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,443,645	1
2	Restatements (describe):		2
3	PY Adjustment	3,955,870	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 16,399,515	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	600,019	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)	\$ 600,019	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 16,999,534	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning: 07/1/2024

Ending: 06/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 22,670,643	1
2	Discounts and Allowances for all Levels	(14,260,175)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,410,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,046,945	6
7	Oxygen	3,243	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,050,188	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	11,857	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,600	16
17	Sale of Drugs	107,967	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,522	19
20	Radiology and X-Ray	9,779	20
21	Other Medical Services	134,638	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 273,363	23
	D. Non-Operating Revenue		
24	Contributions	35,316	24
25	Interest and Other Investment Income***	625	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,941	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	13,154	27
28	Miscellaneous - see attached schedule	12,226,037	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,239,191	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 24,009,151	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,711,092	31
32	Health Care	5,842,974	32
33	General Administration	3,903,797	33
	B. Capital Expense		
34	Ownership	811,339	34
	C. Ancillary Expense		
35	Special Cost Centers	9,711,711	35
36	Provider Participation Fee	428,218	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 23,409,131	40
41	Income before Income Taxes (line 30 minus line 40)**	600,020	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 600,020	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 768,362.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,593,797.00	45
46	MMAI-Medicaid is the Primary Payer	280,077.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	7,064,699.00	48
49	Medicare Part A	1,142,908.00	49
50	Other-(specify) Medicare Managed, Advantage, Veteran, Other	401,289.00	50
51	Other-(specify) C/A Ancillary Accounts	-2,840,664.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,410,468	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	1,928	2,189	\$ 151,032	\$ 69.00	1
2	Assistant Director of Nursing	244	264	14,629	55.41	2
3	Registered Nurses	20,937	23,838	1,085,353	45.53	3
4	Licensed Practical Nurses	9,837	10,798	398,988	36.95	4
5	CNAs & Orderlies	85,580	94,997	2,434,765	25.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,336	2,540	56,912	22.41	8
9	Activity Director	568	672	21,503	32.00	9
10	Activity Assistants	5,411	5,988	119,291	19.92	10
11	Social Service Workers	2,475	2,780	114,774	41.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,332	5,854	161,402	27.57	17
18	Housekeepers	16,185	17,915	343,280	19.16	18
19	Laundry					19
20	Administrator	3,011	3,591	289,601	80.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	550	644	29,325	45.54	23
24	Clerical	8,619	9,274	232,964	25.12	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)	10,110	10,953	281,046	25.66	32
33	Other(specify) Marketing, AL/IL	146,743	160,547	4,195,964	26.14	33
34	TOTAL (lines 1 - 33)	319,866	352,844	\$ 9,930,829 *	\$ 28.15	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly Fee	24,000	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly Fee	14,555	V10-3	38
39	Pharmacist Consultant	Monthly Fee	8,447	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly Fees	212	V11-3	44
45	Social Service Consultant	Monthly Fees	12,979	V12-3	45
46	Other(specify)				46
47					47
48	Preists/Organist	Monthly Fees	11,253	V12-3	48
49	TOTAL (lines 35 - 48)		\$ 71,446		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	10,319	\$ 721,867	V10-3	50
51	Licensed Practical Nurses	72	5,285	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10,391	\$ 727,152		53

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

** See instructions.

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
Maureen Tokar	Administrator	0	\$ 128,322	Workers' Compensation Insurance		\$ 41,311	IDPH License Fee		\$
Dawn Cohn	Executive Director	0	161,279	Unemployment Compensation Insurance		1,456	Advertising: Employee Recruitment		6,140
				FICA Taxes		688,047	Health Care Worker Background Check		493
				Employee Health Insurance		747,617	(Indicate # of checks performed 49)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		23,500
				Disability Insurance		19,043	Facility Licenses		2,403
				Life Insurance		17,790	Subscriptions		628
				Retirement Benefits		186,898	Alloc - FSCSC (See Page 6A Alloc)		8,871
TOTAL (agree to Schedule V, line 17, col. 1)				Tuition		2,000	Less: HO AL/IL Allocation		(3,149)
(List each licensed administrator separately.)			\$ 289,601	Alloc - FSCSC (See Page 6A Alloc)		293,128	Less: Public Relations Expense		()
B. Administrative - Other				Less: HO AL/IL Allocation		(118,805)	PAC and Lobbying payments		(0)
Description			Amount				All non-allowable advertising		()
Franciscan Sisters of Chicago			\$ 1,076,523	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,878,485	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,886
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
				Description		Line #	Description		Amount
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,076,523				Out-of-State Travel		\$
(Attach a copy of any management service agreement)									
C. Professional Services							In-State Travel		
Vendor/Payee	Type		Amount						
Lang Technologies	Software		\$ 2,528						
Inovalon Provider Inc	Software		879						
Plante Moran	Audit/Tax/Cost Report		12,865						
Airdo Werwas LLC	Legal		10,672						
Arlo Walsman	Legal		100,000						
McVey Law LLC	Legal		21,877						
Polsinelli Shughart, PC	Legal		251						
Settlement overpmt			(50,000)				Seminar Expense		9,900
							Alloc - FSCSC (See Page 6A Alloc)		31,955
							Less: HO AL/IL Allocation		(11,343)
							Entertainment Expense		()
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL		\$ 30,512
(For legal fee disclosure, see page 39 of instructions)			\$ 44,583						

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name

LEADING AGE

Amount

23,500

23,500

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.

LEADING AGE

0

0

0

0

Total
- (4)

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

LEADING AGE

0

0

0

0

23,500

Total
- (5)

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

\$

58,372

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.

\$

428,218

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

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

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

Yes

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

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

\$

Yes

Has any meal income been offset against related costs?

Indicate the amount.

\$

15,460
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

N/A

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

Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (13)

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

Firm Name:

CLA

Yes
- (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.