

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0005520

Facility Name: Mount St Joseph

Address: 24955 North Hwy 12Lake Zurich60047
NumberCityZip Code

County: Lake

Telephone Number: 847-438-5050Fax # 847-719-1060

HFS ID Number:

Date of Initial License for Current Owners: 1947

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: Javashree EaswarTelephone Number: 847-438-5050
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2024 to 06/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Sr. Janet Kosman

(Title) Director

Paid Preparer

(Signed)

(Print Name and Title) Joseph HughesCPA

(Firm Name & Address)

(Telephone) (312)922-7241Fax # 312-922-4458

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

Facility Name & ID Number

Mount St Joseph

0005520

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3		Intermediate (ICF)		3
4	129	Intermediate/DD	129	47,085
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	129	TOTALS	129	47,085

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		28,381			726		29,107	11	
12	SC								12	
13	DD 16 OR LESS								13	
14	TOTALS		28,381			726		29,107	14	

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

61.82%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 1947

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

YES ☐ Date 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: 06/30/2025 Fiscal Year: 06/30/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	222,568			222,568		222,568	(35,933)	186,635			1
2	Food Purchase		201,764		201,764		201,764	(23,203)	178,561			2
3	Housekeeping	488,555			488,555		488,555		488,555			3
4	Laundry	41,190	3,320		44,510		44,510		44,510			4
5	Heat and Other Utilities			361,344	361,344		361,344	(41,555)	319,789			5
6	Maintenance	259,439	322,100		581,539		581,539		581,539			6
7	Other (specify):*											7
8	TOTAL General Services	1,011,752	527,184	361,344	1,900,280		1,900,280	(100,691)	1,799,589			8
	B. Health Care and Programs											
9	Medical Director			72,000	72,000		72,000		72,000			9
10	Nursing and Medical Records	3,573,074	181,041	19,884	3,773,999	(95,550)	3,678,449		3,678,449			10
10a	Therapy	116,993			116,993		116,993		116,993			10a
11	Activities											11
12	Social Services		648	40,000	40,648		40,648		40,648			12
13	CNA Training					95,550	95,550		95,550			13
14	Program Transportation			42,225	42,225		42,225		42,225			14
15	Other (specify):* Day Training	778,045	23,203	99,821	901,069		901,069	(901,069)				15
16	TOTAL Health Care and Programs	4,468,112	204,892	273,930	4,946,934		4,946,934	(901,069)	4,045,865			16
	C. General Administration											
17	Administrative	58,500			58,500		58,500		58,500			17
18	Directors Fees											18
19	Professional Services			130,508	130,508		130,508		130,508			19
20	Dues, Fees, Subscriptions & Promotions			11,967	11,967		11,967		11,967			20
21	Clerical & General Office Expenses	578,411			578,411	(17,688)	560,723		560,723			21
22	Employee Benefits & Payroll Taxes			875,711	875,711		875,711	(85,623)	790,088			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,445	108,445		108,445		108,445			26
27	Other (specify):*											27
28	TOTAL General Administration	636,911		1,126,631	1,763,542	(17,688)	1,745,854	(85,623)	1,660,231			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,116,775	732,076	1,761,905	8,610,756	(17,688)	8,593,068	(1,087,383)	7,505,685			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			1,275,655	1,275,655		1,275,655		1,275,655			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,929	150,929		150,929	(150,929)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles					17,688	17,688		17,688			35
36	Other (specify):*											36
37	TOTAL Ownership			1,726,584	1,726,584	17,688	1,744,272	(450,929)	1,293,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			381,128	381,128		381,128		381,128			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			381,128	381,128		381,128		381,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,116,775	732,076	3,869,617	10,718,468		10,718,468	(1,538,312)	9,180,156			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		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	Governmental Sponsored Programs	(59,136)	K1 & K2	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	Developmental Day Training	(901,069)	K15	22
23	Payroll Tax & Benefits - Day Training	(85,623)	K22	23
24				24
25				25
26				26
27				27
28				28
29	Utilities	(41,555)	K5	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	(1,087,383)		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
Daughters of St. Mary of Providence	100%					

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent	\$ 300,000	Daughters of St. Mary of Providence	100%	\$	\$ (300,000)	1
2	V		Interest	150,929	Daughters of St. Mary of Providence	100%		(150,929)	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			\$ 450,929			\$	\$ * (450,929)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Ownership Listing-2

ID# 0005520

07/01/2024

06/30/2025

Operator/Licensee

Operator/Licensee

Place of Residence

Building Co. Co.

Co. / Home Office

Co. / Home Office

M.I.

Last Name

State

Perc

Perce

Percent

Stage

76								76
77								77
78								78
79								79
80								80
81								81
82								82
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144								144
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148								148
149								149
150								150

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								4
5								5
6								6
7								7
8								8
9								9
10								10
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16								16
17								17
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19								19
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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	Sister Kathy Stark	Director	Superior	0.00		84	100.00	Stipend	\$ 58,500	L17,C1	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	\$ 58,500		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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	Daughters Of St Mary						\$					\$	1		
2	Of Providence	X			\$10,000.00	9/12/12		6,335,958		2,515,479		0.0600	150,929	2	
3													3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$10,000.00		\$	6,335,958	\$	2,515,479			\$	150,929	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	6,335,958	\$	2,515,479			\$	150,929	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.)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. 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 Mount St Joseph COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 168,131 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 2

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? 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 X 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 X 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	
Use		Square Feet		Year Acquired		Cost	
1	Home	6,969,600		1935		\$ 8,000	
2							
3	TOTALS	6,969,600				\$ 8,000	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	129		1969	1969	\$ 5,011,610	\$		\$	\$	5,011,610	4
5											5
6			1990	1990	2,361,653					2,361,653	6
7			1990	1990	68,729					68,729	7
8											8
	Improvement Type**										
9				1993	29,005					29,005	9
10				1994	93,489					93,489	10
11				1995	44,713					44,713	11
12				1996	18,082					18,082	12
13				1997	42,570					42,570	13
14				1998	17,423					17,423	14
15				1999	21,853					21,853	15
16				2001	4,700					4,700	16
17				2005	22,748					22,748	17
18				2006	12,917					12,917	18
19				2007	82,454					82,454	19
20				1991	74,205					74,205	20
21				1992	90,293					90,293	21
22				1993	180,181					180,181	22
23				1994	178,251					178,251	23
24				1995	231,228					231,228	24
25				1996	82,875					82,875	25
26				1997	71,814					71,814	26
27				1998	116,448					116,448	27
28				1999	121,823					121,823	28
29				2000	37,015					37,015	29
30				2001	76,812					76,812	30
31				2002	112,086					112,086	31
32				2003	250,123					250,123	32
33				2004	402,099					402,099	33
34				2005	661,395					661,395	34
35				2006	964,742					964,742	35
36				2007	667,688					667,688	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 Mount St Joseph

0005520

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Land Improvements		\$	\$		\$	\$		37
38	Prior Year	2008	156,512					156,512	38
39		2009	157,759					157,759	39
40	6 Sandstone Bases & Crosses	11/24/2010	2,922					2,922	40
41	Repave Parking Lots	9/6/2012	149,300					149,300	41
42	Moselle - sand filter rework for septic system renovation	11/3/2014	45,250					45,250	42
43	Everlasting Memorials	2/11/2015	3,509					3,509	43
44									44
45									45
46		2008	1,945,635					1,945,635	46
47		2009	351,662					351,662	47
48		2010	1,548,258					1,548,258	48
49		2011	455,061					455,061	49
50		2012	9,478,660	1,238,530		1,238,530		10,779,446	50
51	Chapel Window Replacement - Payment NEPCO	1/15/2013	62,000						51
52	Chapel Window Replacement - Payment NEPCO	1/31/2013	106,832						52
53	Dry Sprinkler Replacement	2013	15,480						53
54	St Rose Sprinkler Replacement	2013	4,500						54
55	Chapel Window Replacement - Payment NEPCO	2013	152,855						55
56	Chapel Heater Replacement	2013	5,100						56
57	Decorative Pole Light	2013	2,600						57
58	Chapel Renovation - Payment to NEPCO	10/31/2013	147,308						58
59	Priest House Renovation	2014	40,000						59
60	Priest House Light Pole and Fixture	2014	5,100						60
61	Guanelia Hall Renovation	2014	4,569,130						61
62	Chairs and Tables	2014	5,950						62
63	Ceiling Fixtures and Lights	2014	1,269						63
64	Shielding Cable & Annunciators	2014	3,820						64
65	Annunciator Panel and Lock	2014	1,620						65
66	Roof Replacement	7/9/2014	3,995						66
67	Angle Guardian Roofing	7/10/2014	36,450						67
68	Angle Guardian Roofing	7/11/2014	36,527						68
69	Chapel Bathroom Renovation	7/31/2014	5,500						69
70	TOTAL (lines 4 thru 69)		\$ 31,651,588	\$ 1,238,530		\$ 1,238,530	\$	\$ 27,746,338	70

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

Facility Name & ID Number Mount St Joseph

0005520

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 31,651,588	\$ 1,238,530		\$ 1,238,530	\$	\$ 27,746,338	1
2	Boiler Replacement	2014	8,260						2
3	Campus Network Infrastructure Installation	2015	133,478						3
4	Nursing Station Windows	2015	47,282						4
5	Gazebo Screens	2015	11,250						5
6	St Joseph Hall Renovation	2015	5,687,799						6
7	NEPCO - Asphalt Repair & Sealing	2015	154,000						7
8	Campus Network Infrastructure Installation	2015	106,782						8
9	Heat Exchangers	2016	10,600						9
10	Campus Network Infrastructure Installation	2016	25,792						10
11	EM Lighting	2016	9,750						11
12	Nelson Fire Protection - Sacred Heart Sprinklers	2016	4,462						12
13	Tabernacle Refinish	2016	1,656						13
14	NEPCO - Water Level Monitor	2016	3,200						14
15	NEPCO - Conduit Repairs and Replacement	2016	42,000						15
16	NEPCO - EM Lighting for St Clare	2016	14,950						16
17	Everlasting Memorial Crosses	7/1/2016	3,509						17
18	Large Chimney Renovation	7/5/2016	63,628						18
19	Fish Lake Cedar Fence	2016	2,270						19
20	New Wall	2016	672,520						20
21	Therapy Building roof and HVAC	2016	1,950,941						21
22	Heat Exchanger Replacement	2017	9,000						22
23	Telecom Network Cat 6 cables	9/20/2017	30,223						23
24	Steam Boiler Tank	2017	38,940						24
25	HDPE Conduit Boring and Placement	2017	13,201						25
26	Therapy Building Stairwell Enclosure	2017	23,000						26
27	Septic Tank	2018	49,214						27
28	Therapy Building Emergency Lights	2018	40,250						28
29	Kitchen Hot Water Heater	2018	5,017						29
30	Kitchen P-Trap	2018	3,822						30
31	Therapy Building Water Softener	2015	6,055						31
32	Angel Guardian Window Replacement	2018	294,048						32
33	Angel Guardian Building Repairs	10/10/2018	3,148						33
34	TOTAL (lines 1 thru 33)		\$ 41,121,635	\$ 1,238,530		\$ 1,238,530	\$	\$ 27,746,338	34

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

Facility Name & ID Number Mount St Joseph

0005520

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

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

1 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		\$ 41,121,635	\$ 1,238,530		\$ 1,238,530	\$	\$ 27,746,338	1
2	New Wall Variable Frequency Drive	11/16/2018	7,580						2
3	New Wall Repairs - Municipal well	2019	5,750						3
4	DeFranco Plumbing - Storage Tank Install	2019	73,312						4
5	Municipal Well & Pump - New Tanks	2019	60,210						5
6	Septic Field Renovation	2019	103,713						6
7	Septic Field Renovation -Moselle	7/17/2019	107,063						7
8	Septic Field Renovation -Moselle	2019	171,175						8
9	Septic Field Renovation - Caldwell	2019	3,118						9
10	Septic Field Renovation -Moselle	2019	61,626						10
11	Septic Field Renovation - Caldwell	2019	3,957						11
12	Septic Field Renovation -Moselle	2019	84,059						12
13	Septic Field Renovation -Moselle	2019	62,299						13
14	St Aloysius Restroom Renovation - NEPCO	7/12/2019	32,100						14
15	St Aloysius Restroom Renovation - NEPCO	2020	91,600						15
16	St Aloysius New AC - Climate Services	2020	17,275						16
17	St Aloysius New AC - Climate Services	2020	16,400						17
18	St Aloysius Restroom Renovation - NEPCO	2020	79,145						18
19	Septic Field Renovation -Moselle	2020	76,782						19
20	St Aloysius Restroom Renovation - NEPCO	2020	121,600						20
21	Septic Field Renovation -Moselle	9/8/2020	37,941						21
22	St Aloysius Restroom Renovation - NEPCO	12/8/2020	118,720						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 42,457,060	\$ 1,238,530		\$ 1,238,530	\$	\$ 27,746,338	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	\$2,086,930	\$21,304	\$21,304	\$		\$2,068,688	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,086,930	\$21,304	\$21,304	\$		\$2,068,688	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$44,551,990	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,259,834	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,259,834	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$29,815,026	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	Farm Equipment	\$40,316	\$	\$40,316	86
87	Vehicles	443,443	13,380	439,944	87
88	Non-Care	1,135,606	2,441	1,132,568	88
89					89
90					90
91	TOTALS	\$1,619,365	\$15,821	\$1,612,828	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
- X
- NO
16. Rental Amount for movable equipment: \$ 17,688
- 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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER CNA

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

HOURS PER CNA

60

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)		12,320		12,320
4	Clinical Wages (b)		83,230		83,230
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 95,550	\$	\$ 95,550
10	SUM OF line 9, col. 1 and 2 (e)	\$ 95,550			

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	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	28

(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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L9,C3	12 visits	42,000				12	42,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 42,000		\$	\$	12	\$ 42,000	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	\$ 201,988	\$ 201,988	1
2	Cash-Patient Deposits	124,429	124,429	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	556,982	556,982	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,419	94,419	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Lease Assets</u>	894,982	894,982	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,872,800	\$ 1,872,800	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,645	5,645	12
13	Land	8,000	8,000	13
14	Buildings, at Historical Cost	7,437,391	7,437,391	14
15	Leasehold Improvements, at Historical Cost	28,459,530	35,722,545	15
16	Equipment, at Historical Cost	3,003,419	3,003,419	16
17	Accumulated Depreciation (book methods)	(29,830,847)	(33,966,283)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	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)	\$ 9,083,138	\$ 12,210,717	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,955,938	\$ 14,083,517	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,627	\$ 167,627	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	124,429	124,429	28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	503,474	503,474	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	20,382	20,382	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	<u>Lease Asset Liabilities</u>	896,054	896,054	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,831,966	\$ 1,831,966	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,000	200,000	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)	\$ 200,000	\$ 200,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,031,966	\$ 2,031,966	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,923,972	\$ 12,051,551	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,955,938	\$ 14,083,517	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,306,292	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,306,292	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(350,354)	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)	\$ (350,354)	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)	\$ 10,955,938	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mount St Joseph

0005520

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,011,121	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,011,121	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	515,945	24
25	Interest and Other Investment Income***	17,086	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 533,031	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sister Contributions	2,346,715	28
28a	Developmental Training	1,476,617	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,823,332	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,367,484	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,937,662	31
32	Health Care	3,907,162	32
33	General Administration	1,660,231	33
	B. Capital Expense		
34	Ownership	1,293,343	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	381,128	36
	D. Other Expenses (specify):		
37	Day Training Expenses	1,538,312	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,717,838	40
41	Income before Income Taxes (line 30 minus line 40)**	(350,354)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (350,354)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,539,942.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	202,498.00	48
49	Medicare Part A		49
50	Other-(specify) SSA/SSI	1,268,681.00	50
51	Other-(specify)		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)	\$ 6,011,121	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
2	Assistant Director of Nursing					2
3	Registered Nurses	29,343	30,566	999,192	32.69	3
4	Licensed Practical Nurses	9,332	9,721	285,015	29.32	4
5	CNAs & Orderlies	1,309	1,364	26,026	19.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,110	4,281	116,993	27.33	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,420	8,771	176,378	20.11	14
15	Cook Helpers/Assistants	2,475	2,581	46,191	17.90	15
16	Dishwashers					16
17	Maintenance Workers	9,584	9,984	259,439	25.99	17
18	Housekeepers	30,077	31,267	488,554	15.63	18
19	Laundry	2,228	2,321	41,190	17.75	19
20	Administrator	4,470	4,688	75,000	16.00	20
21	Assistant Administrator	5,224	5,478	63,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,795	25,787	578,411	22.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	8,912	9,283	241,446	26.01	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	116,441	121,293	1,941,895	16.01	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	46,393	48,326	778,045	16.10	33
34	TOTAL (lines 1 - 33)	303,113	315,711	\$ 6,116,775 *	\$ 19.37	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dentist</u>	189	12,330	L10,C3	46
47	<u>Psychiatrist</u>	26	7,700	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	215	\$ 20,030		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

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

N/A

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.

N/A

Total
- (4)

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

N/A

Total
- (5)

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

\$

78,320

Line

L10
- (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.

\$

381,128

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

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

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

Yes

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

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

\$

N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$

N/A
- (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.

\$

None

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

N/A

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

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

No

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

\$

N/A
- (13)

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

Yes

Firm Name:

Bansley, Brescia & Co., P.C.
- (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.

N/A

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