

		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: 0054890

Facility Name: St Claras Rehab Senior Care

Address: 1450 Castle Manor Dr Lincoln 62656

NumberCityZip Code

County: Logan

Telephone Number: 217-735-1507 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: Pre-1970

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501 C 3	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.	☐	
		☐	Limited Liability Co.	☐	
		☐	Trust	☐	
		☐	Other	☐	

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

Name: Daniel CurryTelephone Number: 309-823-7164Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Daniel Curry

(Title) EVP & CFO

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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 St Claras Rehab Senior Care # 0054890 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	6,507	10,627	3,173	86	10,214	2,190	1,463	34,260	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,507	10,627	3,173	86	10,214	2,190	1,463	34,260	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.81%

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 3-1-2018

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 99

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number St Claras Rehab Senior Care # 0054890 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	366,858	25,987	10,814	403,659		403,659		403,659			1
2	Food Purchase		311,008		311,008		311,008		311,008			2
3	Housekeeping	160,346	41,233		201,579		201,579		201,579			3
4	Laundry	70,643	36,143		106,786		106,786		106,786			4
5	Heat and Other Utilities			252,730	252,730		252,730		252,730			5
6	Maintenance	92,502	164,965	74,005	331,472		331,472		331,472			6
7	Other (specify):*											7
8	TOTAL General Services	690,349	579,336	337,549	1,607,234		1,607,234		1,607,234			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,216,673	141,925	333,440	3,692,038	219,685	3,911,723		3,911,723			10
10a	Therapy		260,411	36,489	296,900	(288,871)	8,029		8,029			10a
11	Activities	78,500	5,533		84,033		84,033		84,033			11
12	Social Services	64,659		4,382	69,041		69,041		69,041			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,359,832	407,869	398,311	4,166,012	(69,186)	4,096,826		4,096,826			16
	C. General Administration											
17	Administrative	96,801			96,801		96,801		96,801			17
18	Directors Fees											18
19	Professional Services			542,503	542,503		542,503	(1,997)	540,506			19
20	Dues, Fees, Subscriptions & Promotions			715,630	715,630	(632,868)	82,762	(20,740)	62,022			20
21	Clerical & General Office Expenses	347,165	46,266	152,705	546,136	(227,714)	318,422		318,422			21
22	Employee Benefits & Payroll Taxes			1,258,886	1,258,886		1,258,886		1,258,886			22
23	Inservice Training & Education			2,021	2,021		2,021		2,021			23
24	Travel and Seminar			480	480		480		480			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			206,832	206,832		206,832		206,832			26
27	Other (specify):* Lost Resident Items			63,819	63,819		63,819	(61,075)	2,744			27
28	TOTAL General Administration	443,966	46,266	2,942,876	3,433,108	(860,582)	2,572,526	(83,812)	2,488,714			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,494,147	1,033,471	3,678,736	9,206,354	(929,768)	8,276,586	(83,812)	8,192,774			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							632,473	632,473			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							212,548	212,548			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			785,964	785,964		785,964	(785,964)				34
35	Rent-Equipment & Vehicles			56,004	56,004		56,004		56,004			35
36	Other (specify):*											36
37	TOTAL Ownership			841,968	841,968		841,968	59,057	901,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			409,073	409,073	296,900	705,973		705,973			39
40	Barber and Beauty Shops			12,427	12,427		12,427		12,427			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					632,868	632,868		632,868			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			421,500	421,500	929,768	1,351,268		1,351,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,494,147	1,033,471	4,942,204	10,469,822		10,469,822	(24,755)	10,445,067			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	(8,998)			17
18	Fines and Penalties	(49,075)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,997)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)			24
25	Fund Raising, Advertising and Promotional	(11,742)			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 Real estate taxes paid on non resident prop				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,812)		\$	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)	59,057		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 59,057		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (24,755)		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	xx		21,564	10a	42
43	Prescription Drugs	xx		260,411	10a	43
44	Hospital Services	xx		14,925	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 296,900		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (8,613)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(12,000)	27	11
12		0	33	12
13		(49,075)	27	13
14		(3,129)	20	14
15		(8,998)	20	15
16		0	35	16
17		0	24	17
18		(1,997)	19	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(83,812)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not For Profit Organization				St Clara's Senior Servi	Lincoln IL	Sponsor Org
(Not for profit Board of Directors-No individual ownership)				Castle Manor	Lincoln IL	Supportive Living
List of Board Members is attached						

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			\$			\$	\$	1
2	V	34	Rent	785,964	St Clara's Senior Services Inc.			(785,964)	2
3	V								3
4	V	30	Depreciation		St Clara's Senior Services Inc.		632,473	632,473	4
5	V	32	Interest & Loan Fee Amort		St Clara's Senior Services Inc.		212,548	212,548	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			\$ 785,964			\$ 845,021	\$ * 59,057	14

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

STATE OF ILLINOIS				Ownership Listing-1			
St Claras Rehab Senior Care							
ID#		0054890					
Report Period Beginning:		01/01/2025		Heritage Operations Gr			
Ending:		12/31/2025		St. Clara's Senior Services Inc			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management			
-Owners of companies must be listed instead of company names.				Co./Home Office			
-Names of trust beneficiaries must be listed.							
First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Ownership Percentage
1							1
2		St Clara's Manor, Inc. - An Illinois Not For Profit	Lincoln	IL	100.00000		2
3							3
4		St. Clara's Senior Services, Inc. An Illinois	Lincoln	IL		100.00000	4
5		Not For Profit					5
6							6
7	Craig	Hart Trust	Hudson	IL			28.42000
8	Joseph	Warner Trust	Bloomington	IL			4.00000
9	Linda	Hagi Trust	Bloomington	IL			2.41000
10	Janice	Hart Trust	Streator	IL			2.41000
11	Timothy	Jefferson	Champaign	IL			16.10000
12	Paul	Jefferson	Bloomington	IL			16.10000
13	Robert	Dickson Family Trust	Naples	IL			1.28000
14	Cheryl	Lowney	Lincoln	IL			0.77000
15	Steven	Wannemacher	Bloomington	IL			1.85000
16	Bruce	Hart	Phoenix	IL			7.30700
17	Brian	Hart	Lake Forest	IL			7.30700
18	Benjamin	Hart Trust	Bloomington	IL			7.30700
19	Jerry	Westwood Trust	Naples	IL			1.60000
20	Van	Freiderich	Congerville	IL			0.70000
21	Todd	Hart Trust	Bloomington	IL			0.69000
22	Allan	Hart	Morton	IL			0.69000
23	Connie	Hoselton	Lexington	IL			0.34000
24	David	Fehrenbacher	Lincoln	IL			0.08000
25	David	Wegman	Normal	IL			0.08000
26	David	Hoeper	Fishers	IL			0.05000
27	David	Underwood	Peoria	IL			0.08000
28	Jane	Hart Trust	Hudson	IL			0.43000
29							29
30							30
31							31
32							32
33							33
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36							36
37							37
38							38
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68							68
69							69
70							70
71							71
72							72
73							73
74							74
75							75

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								\$		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number St Claras Rehab Senior Care # 0054890 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Heartland Bank & Trust		xx	New Building Mortgage			\$	3,185,666			\$	212,548	1
2	Heartland Bank & Trust		xx	New Building Mortgage				2,938,505					2
3	Heartland Bank & Trust		xx	New Building Mortgage				3,668,112					3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	9,792,283			\$	212,548	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	9,792,283			\$	212,548	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
Not for profit entity operating under exemption from paying real estate taxes					
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

St Claras Rehab Senior Care

COUNTY

Logan

FACILITY IDPH LICENSE NUMBER

0054890

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. None		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 75,442 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (xx) (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 (xx) (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).
St. Clara's Senior Services - Owns real and personal property.
Castle Manor - Supportive living facility located adjacent to St. Clara's Manor. Separately owned with separate management but also sponsored by St. Clara's Senior Services

F. List the bed capacity for the building if it differs from the licensed total. Same
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 xx If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Nursing Facility			2010	\$	829,423	1
2							2
3	TOTALS				\$	829,423	3

Facility Name & ID Number St Claras Rehab Senior Care

0054890

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	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	99		2018	18516091	\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	No Improvements in 2018			2018						9
10										10
11	No Improvements in 2019			2019						11
12										12
13	Planted trees throughout the property			2020	17,570					13
14										14
15	No Improvements in 2021			2021						15
16										16
17	Installed new door security control hardware			2022	3,968					17
18										18
19	Install (46) carbon dioxide detectors			2023	13,225					19
20	Installed new lightening strike doors			2023	490					20
21										21
22	Installed new gateway for nurse call system			2024	3,206					22
23										23
24	Installed (4) resident room PTAC units			2025	5,176					24
25	Acquired delayed egress closure system			2025	7,529					25
26	Repaired water leaks on the main 3" water line in			2025	15,618					26
27	(3) different locations									27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35	Book Depreciation					466,256		466,256		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,677,867	\$ 166,217	\$ 166,217	\$		\$	71
72	Current Year Purchases	3,233						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,681,100	\$ 166,217	\$ 166,217	\$		\$	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		2015 Grand Caravan	2015	\$ 32,723	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 32,723	\$	\$	\$		\$	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)	\$ 2,610,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 632,473	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 632,473	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)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: St. Clara's Senior Services Inc
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:	2018	99	3-1-18	\$ 785,965	40		3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 785,965			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
- None

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 56,004
- Description: Oxygen concentrators, copiers and printers
- (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	None		\$	\$	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 3-1-18
- Ending 2-28-58

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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		hrs	\$		\$ 150,275	\$		\$ 150,275	1
2	Licensed Speech and Language Development Therapist		hrs			77,812			77,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			180,986	0		180,986	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				260,411		260,411	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					36,489			36,489	13
14	TOTAL			\$		\$ 445,562	\$ 260,411		\$ 705,973	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.

12/31/2025

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 329,233	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	96,876		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,726		30
31	Accrued Taxes Payable (excluding real estate taxes)	(84)		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>Bed Tax</u>	54,880		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 812,631	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 812,631	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 397,389	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,210,020	\$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (977,370)	1
2	Restatements (describe):		2
3	AJE - Adjust Trinity Risk RRG investment to confirmation	14,252	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (963,118)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,360,507	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)	\$ 1,360,507	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)	\$ 397,389	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Claras Rehab Senior Care

0054890

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,963,537	1
2	Discounts and Allowances for all Levels	(1,446,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,516,635	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,140,062	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,140,062	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	169,384	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,427	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	422,849	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	49,019	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 655,679	23
	D. Non-Operating Revenue		
24	Contributions	11,912	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,912	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Item - Refund of Employee	1,506,041	28
28a	Retention Credit		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,506,041	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,830,329	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,607,234	31
32	Health Care	4,166,012	32
33	General Administration	3,433,108	33
	B. Capital Expense		
34	Ownership	841,968	34
	C. Ancillary Expense		
35	Special Cost Centers	421,500	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,469,822	40
41	Income before Income Taxes (line 30 minus line 40)**	1,360,507	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,360,507	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,479,584.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,464,809.78	45
46	MMAI-Medicaid is the Primary Payer	735,826.22	46
47	MMAI-Medicare is the Primary Payer	27,175.00	47
48	Private Pay	2,814,725.12	48
49	Medicare Part A	601,903.00	49
50	Other-(specify) Private Insurance	403,206.88	50
51	Other-(specify) Medicare Cost Report Settlement	27,928.00	51
52	Other-(specify) Medicare Bad Debts	-38,523.00	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)	\$ 8,516,635	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,095	2,205	\$ 135,011	\$ 61.23	1
2	Assistant Director of Nursing	2,587	2,723	92,894	34.11	2
3	Registered Nurses	5,539	5,831	268,189	45.99	3
4	Licensed Practical Nurses	20,373	21,445	749,302	34.94	4
5	CNAs & Orderlies	74,832	78,770	1,971,277	25.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,379	4,609	78,500	17.03	10
11	Social Service Workers	3,747	3,944	64,659	16.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,265	21,332	366,858	17.20	15
16	Dishwashers					16
17	Maintenance Workers	4,067	4,281	92,502	21.61	17
18	Housekeepers	10,044	10,573	160,346	15.17	18
19	Laundry	4,227	4,449	70,643	15.88	19
20	Administrator	1,852	1,950	96,801	49.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,902	9,370	347,165	37.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,909	171,482	\$ 4,494,147 *	\$ 26.21	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		\$ 10,814	Ln 1 Col 3	35
36	Medical Director		24,000	Ln 9 Col 3	36
37	Medical Records Consultant		1,164	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,029	Ln 10a Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,382	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,389		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,901	\$ 203,527	Ln10 Col 3	50
51	Licensed Practical Nurses	1,223	68,524	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides			Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	4,124	\$ 272,051		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
Keary Anderson	Administrator		\$ 96,801	Workers' Compensation Insurance		\$ 64,307	IDPH License Fee		\$
				Unemployment Compensation Insurance		29,829	Advertising: Employee Recruitment		17,047
				FICA Taxes		343,802	Health Care Worker Background Check		
				Employee Health Insurance		781,360	(Indicate # of checks performed _____)		2,632
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		17,226
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		39,588			407
(List each licensed administrator separately.)			\$ 96,801						33,708
B. Administrative - Other									
Description			Amount				Less: Public Relations Expense		()
			\$				PAC and Lobbying payments		(8,613)
							All non-allowable advertising		(385)
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 62,022
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,258,886			
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description		Line #	Description		Amount
Vendor/Payee	Type		Amount				Out-of-State Travel		\$
Heritage Operations Group	Management		\$ 514,331						
Principal Financial	401k management		2,175						
MCL CPA's & Advisors	Audit services		21,650				In-State Travel		
David Fehrenbacher	Medicare consulting		1,000						78
David Underwood	Public Aid consulting		1,350						
							Seminar Expense		402
Legal adj to Zero			1,997						
							Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 542,503				TOTAL		\$ 480

*** 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	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	8,613
	8,613 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	8,613
	8,613 Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	17,226
	17,226 Total
- (5)

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

\$ 5,000

Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 632,868

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? 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.

No
- (11)

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

\$ None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 1,969
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

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

100%

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

NA

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.

\$
- (13)

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

Firm Name: MCK CPA's and Advisors

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.

None Claimed

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

[illegible]

St. Clara's Rehab and Senior Care
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 260,411
Purchased Hospital Services	14,925
Purchased Laboratory Services	12,299
Purchased Radiology Services	9,265
Amount Reclassified to Line 39	\$ <u>296,900</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee	<u>632,868</u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>	
Pharmacy Consultant	\$ <u>8,029</u>

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>	
MDS Coordinators/Care Planners - Line 21, Col 1	\$ (13,513)
Medical Records Specialists - Line 21, Col 1	<u>(214,201)</u>
	<u>(227,714)</u>
Nursing & Medical Records Line 10	<u>227,714</u>