

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0046581</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Joseph Village of Chicago</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2024</u> to <u>6/30/2025</u> 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.	
Address: <u>4021 W Belmont Ave</u> <u>Chicago</u> <u>60641</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider Paid Preparer	
Telephone Number: <u>773-328-5500</u> Fax # <u>773-328-5502</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>1/13/2006</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>54</u>	Skilled (SNF)	<u>54</u>	<u>19,710</u>	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	<u>54</u>	TOTALS	<u>54</u>	<u>19,710</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	782	1,798	455	381	5,293	7,152	2,458	18,319	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	782	1,798	455	381	5,293	7,152	2,458	18,319	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.94%

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 1/13/2006

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 1/13/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 54

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 7/1/2024 Ending: 6/30/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		10,511	532,470	542,981		542,981	21,272	564,253			1
2	Food Purchase		182,237		182,237		182,237	(1,386)	180,851			2
3	Housekeeping	126,509	16,777	1,243	144,529		144,529		144,529			3
4	Laundry		1,929	1,455	3,384		3,384		3,384			4
5	Heat and Other Utilities			167,868	167,868		167,868		167,868			5
6	Maintenance	73,803	37,353	236,007	347,163		347,163	28,723	375,886			6
7	Other (specify):*											7
8	TOTAL General Services	200,312	248,807	939,043	1,388,162		1,388,162	48,609	1,436,771			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,040,388	185,460	913,819	4,139,667		4,139,667		4,139,667			10
10a	Therapy											10a
11	Activities	82,834	391	6,024	89,249		89,249	57,835	147,084			11
12	Social Services	139,262	331	13,531	153,124		153,124	(718)	152,406			12
13	CNA Training											13
14	Program Transportation	14,515	3,941	39,468	57,924		57,924		57,924			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,276,999	190,123	996,842	4,463,964		4,463,964	57,117	4,521,081			16
	C. General Administration											
17	Administrative	146,734		618,591	765,325		765,325	(521,310)	244,015			17
18	Directors Fees											18
19	Professional Services			51,049	51,049		51,049	130,280	181,329			19
20	Dues, Fees, Subscriptions & Promotions			47,413	47,413		47,413	4,271	51,684			20
21	Clerical & General Office Expenses	274,409	5,687	310,746	590,842		590,842	199,087	789,929			21
22	Employee Benefits & Payroll Taxes			937,892	937,892		937,892	127,571	1,065,463			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,279	5,279		5,279	15,386	20,665			24
25	Other Admin. Staff Transportation			2,002	2,002		2,002		2,002			25
26	Insurance-Prop.Liab.Malpractice			160,518	160,518		160,518	(18,623)	141,895			26
27	Other (specify):*											27
28	TOTAL General Administration	421,143	5,687	2,133,490	2,560,320		2,560,320	(63,338)	2,496,982			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,898,454	444,617	4,069,375	8,412,446		8,412,446	42,388	8,454,834			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			496,264	496,264		496,264	6,567	502,831			30
31	Amortization of Pre-Op. & Org.			5,279	5,279		5,279		5,279			31
32	Interest			287,352	287,352		287,352	(4,114)	283,238			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							10,912	10,912			34
35	Rent-Equipment & Vehicles			77,004	77,004		77,004	660	77,664			35
36	Other (specify):*											36
37	TOTAL Ownership			865,899	865,899		865,899	14,025	879,924			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		428,225	1,128,020	1,556,245		1,556,245		1,556,245			39
40	Barber and Beauty Shops			9,971	9,971		9,971	(9,971)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,513	111,513		111,513		111,513			42
43	Other (specify):* AL/IL/Marketing	1,466,951	9,650	1,991,554	3,468,155		3,468,155	(3,468,155)				43
44	TOTAL Special Cost Centers	1,466,951	437,875	3,241,058	5,145,884		5,145,884	(3,478,126)	1,667,758			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,365,405	882,492	8,176,332	14,424,229		14,424,229	(3,421,713)	11,002,516			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	(1,386)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,228)	21		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	(4,114)	32		10
11	Discounts, Allowances, Rebates & Refunds	(242)	21		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	(21,527)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(158,462)	21		24
25	Fund Raising, Advertising and Promotional	(247,947)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	(3,670,843)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,114,749)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	693,036	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 693,036		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,421,713)		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			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	20
2	Other Expenses Related to Lobbying Activities		2
3			3
4	Insurance Settlements	(32,907)	26
5	Barber and Beauty	(9,971)	40
6	Other Income - Enrichment	(718)	12
7	AL/IL - Other	(1,363,853)	43
8	AL/IL - Salary	(1,856,355)	43
9	Miscellaneous Expense	(1,443)	21
10	Legal Settlements	(55,000)	19
11			11
12	Home Office AL/IL Expenses		12
13	Dietary	(14,300)	1
14	Maintenance	(17,530)	6
15	Activities	(38,879)	11
16	Administrative	(28,584)	17
17	Professional Fees	(54,441)	19
18	Dues & Subscriptions	(1,255)	20
19	A&G	(114,884)	21
20	A&G Benefits	(55,039)	22
21	Seminars and Travel	(4,521)	24
22	Insurance	(4,197)	26
23	Depreciation	(4,008)	30
24	RE Taxes	(5,896)	33
25	Rental - Facility & Grounds	(6,660)	34
26	Rent - Equipment	(402)	35
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	(3,670,843)	49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[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
		Franciscan Village	Lemont, IL	Franciscan Sisters of C	Lemont, IL	Religious Cong.
		Mt. Alverna Village/ Ancora	Parma, OH	Franciscan Sisters Chi	Lemont, IL	Corp. Management
		St. Joseph Village	Chicago, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living
		Village at Victory Lakes	Lindenhurst, IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.
		University Place	West Lafayette, IN	St. Jude House	Crown Point, IN	Dom. Viol. Shelter
				Madonna Foundation	Lemont, IL	HS Foundation
				Village at Mercy Creel	Normal, IL	Ind. & Asst. Living

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

☐ YES☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 618,591		100.00%	\$	(618,591)	15
16	V	1	Dietary-Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	35,572	35,572	16
17	V	6	Maintenance - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	34,657	34,657	17
18	V	6	Maintenance - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	11,596	11,596	18
19	V	11	Activities - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	96,714	96,714	19
20	V	17	Administrative - Salaries		Franciscan Sisters of Chicago Service Corporation	100.00%	125,865	125,865	20
21	V	19	Professional Fees		Franciscan Sisters of Chicago Service Corporation	100.00%	239,721	239,721	21
22	V	21	Clerical - Salary		Franciscan Sisters of Chicago Service Corporation	100.00%	409,101	409,101	22
23	V	21	Clerical - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	96,772	96,772	23
24	V	22	Employee Benefits		Franciscan Sisters of Chicago Service Corporation	100.00%	182,610	182,610	24
25	V	24	Seminar and Travel		Franciscan Sisters of Chicago Service Corporation	100.00%	19,907	19,907	25
26	V	26	Professional Fees		Franciscan Sisters of Chicago Service Corporation	100.00%	18,481	18,481	26
27	V	30	Depreciation		Franciscan Sisters of Chicago Service Corporation	100.00%	10,575	10,575	27
28	V	33	Real Estate Taxes		Franciscan Sisters of Chicago Service Corporation	100.00%	5,896	5,896	28
29	V	34	Lease/Rent - Building		Franciscan Sisters of Chicago Service Corporation	100.00%	17,572	17,572	29
30	V	35	Lease/Rent - Equipment		Franciscan Sisters of Chicago Service Corporation	100.00%	1,062	1,062	30
31	V	20	Dues & Subscriptions		Franciscan Sisters of Chicago Service Corporation	100.00%	5,526	5,526	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 618,591			\$ 1,311,627	\$ * 693,036	39

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

VII. RELATED PARTIES								
A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.								
	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Franciscan Village	Lemont, IL	Franciscan Sisters of C	Lemont, IL	Religious Cong.	1
2			Mt. Alverna Village/ Ancora	Parma, OH	Franciscan Sisters Chi	Lemont, IL	Corp. Management	2
3			Addolorata Villa	Wheeling, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living	3
4			The Village of Victory Lakes	Lindenhurst, IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.	4
5			University Place	West Lafayette, IN	St. Jude House	Crown Point, IN	Dom. Viol. Shelter	5
6					Madonna Foundation	Lemont, IL	HS Foundation	6
7					Village at Mercy Creel	Normal, IL	Ind. & Asst. Living	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								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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 Franciscan Sisters of Chicago Service Corp.
Street Address 11500 Theresa Drive
City / State / Zip Code Lemont, IL 60439
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary-Salaries	Expense	146,728,265	10	\$ 382,592	\$ 382,592	13,642,136	\$ 35,572	1
2	6	Maintenance-Salaries	Expense	146,728,265	10	372,756	372,756	13,642,136	34,657	2
3	6	Maintenance-Other	Expense	146,728,265	10	124,716		13,642,136	11,596	3
4	11	Activities-Salary	Expense	146,728,265	10	1,040,211	1,040,211	13,642,136	96,714	4
5	17	Administrative - Salary	Expense	146,728,265	10	1,353,747	1,353,747	13,642,136	125,865	5
6	19	Professional Fees	Expense	146,728,265	10	2,578,323		13,642,136	239,721	6
7	21	Clerical - Salary	Expense	146,728,265	10	4,400,097	4,400,097	13,642,136	409,101	7
8	21	Clerical - Other	Expense	146,728,265	10	1,040,830		13,642,136	96,772	8
9	22	Employee Benefits	Expense	146,728,265	10	1,964,064		13,642,136	182,610	9
10	24	Seminar and Travel	Expense	146,728,265	10	214,111		13,642,136	19,907	10
11	26	Insurance	Expense	146,728,265	10	198,778		13,642,136	18,481	11
12	30	Depreciation	Expense	146,728,265	10	113,743		13,642,136	10,575	12
13	33	Real Estate Taxes	Expense	146,728,265	10	63,411		13,642,136	5,896	13
14	34	Lease/Rent - Building	Expense	146,728,265	10	188,991		13,642,136	17,572	14
15	35	Lease/Rent - Equipment	Expense	146,728,265	10	11,424		13,642,136	1,062	15
16	20	Dues & Subscriptions	Expense	146,728,265	10	59,436		13,642,136	5,526	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 14,107,230	\$ 7,549,403		\$ 1,311,627	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Illinios Finance Authority		X	Refinanced Debt	Varies	06/28/2017	\$ 3,917,310	\$ 2,728,500	05/15/2047	4.8600	\$ 140,082	1	
2	Illinios Finance Authority		X	Refinanced Debt	Varies	10/14/2021	3,234,522	3,122,322	05/15/2050	4.9900	68,498	2	
3	Illinios Finance Authority		X	Refinanced Debt	Varies	05/15/2023	7,247,610	7,089,000	05/15/2047	2.8200	257,659	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 14,399,442	\$ 12,939,822			\$ 466,239	9	
	B. Non-Facility Related*												
10	Interest Income										(4,114)	10	
11	Alloc. Non-Allowable AI/IL										(175,373)	11	
12	Allocation variance										(3,514)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (183,001)	14	
15	TOTALS (line 9+line14)						\$ 14,399,442	\$ 12,939,822			\$ 283,238	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2024 report.				\$	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 <table><tr><td></td><td>8</td></tr></table>							8								
	8														
Real Estate Tax Bill for Calendar Year: 2020 <table><tr><td></td><td>9</td></tr><tr><td>2021</td><td>10</td></tr><tr><td>2022</td><td>11</td></tr><tr><td>2023</td><td>12</td></tr><tr><td>2024</td><td>13</td></tr></table>							9	2021	10	2022	11	2023	12	2024	13
	9														
2021	10														
2022	11														
2023	12														
2024	13														
		FOR BHF USE ONLY													
		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.

FACILITY NAME St Joseph Village of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046581

CONTACT PERSON REGARDING THIS REPORT Matt Larsh

TELEPHONE 630-368-3666 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:

46,408

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

2

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(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).
Assisted Living - 42,457 Square Feet
Dr. Officese - 180 Square Feet
Therapy Room - 1,840 Square Feet
Retail Food - 2,590 Square Feet, Chape - 4,110 Square Feet

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

N/A

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

Yes

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

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

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.

N/A

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:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2003	\$ 141,036	1
2					2
3	TOTALS			\$ 141,036	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	54		2006	2006	\$ 10,146,462	\$		\$	\$	4
5			2007	2007	(315,077)					5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2007		24,402					9
10	Various		2008		29,726					10
11	Various		2009		6,967					11
12	Various		2010		4,092					12
13	Various		2012		14,038					13
14	Various		2013		10,229					14
15	Various		2014		13,101					15
16	Various		2015		9,795					16
17	Various		2016		3,361					17
18	Various		2017		31,575					18
19	Various		2018		6,281					19
20	Various		2019		66,501					20
21	Various		2020		122,087					21
22	Fox Valley Fire Elevator Shunt Trip Work - SNF Wing- (Total Cost: 97			2022	4,860					22
23	Berry Electric Contracting - Elevator - SNF Wing- (Total Cost: 21020)			2022	10,436					23
24	Ashland Plumbing & Heating -Boiler- (Total Cost: 23548)			2022	11,691					24
25	CareSheetMetal&Roofing -Roof Replacement - (Total cost: 179242)			2022	88,989					25
26	Zentel Tech Kitchen MAU Compresor - (Total cost: 7939)			2022	3,942					26
27	Daugherty Sales 2 Weil ejector pumps - (Total cost: 11190)			2023	5,556					27
28	Tom Callahan Plumbing install pumps - (Total cost: 6550)			2023	3,252					28
29	Lionhart - Generator Maintenance CAT - (Total cost: 2796.74)			2022	1,389					29
30	DirectSupply- Nurse Call System Wireless - (Total cost: 195008.67)			2023	195,009					30
31	Fire Smoke & Fire Dampers- Res Rooms/Halls-NF/AL(TC \$16,815)			2023	8,349					31
32	Repairs to the Fire Sprinklers- Res Rooms/Halls-NF/AL(TC \$3,784)			2023	1,879					32
33	Signarama - Interior Signage - (Total Cost: 14974.88)			2024	7,435					33
34	Synergy project - Carpentry - (Total Cost: 27345)			2024	13,576					34
35	Synergy Project Drywall - (Total Cost: 60832)			2024	30,202					35
36	Synergy project Flooring - (Total Cost: 453200)			2024	225,002					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 St Joseph Village of Chicago

0046581

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	RDG Planning - Project planning -General - (Total Cost: 380355.4	2024	\$ 188,837	\$		\$	\$	\$	37
38	FM Dev Fee -General - (Total Cost: 114250)	2024	56,722						38
39	Synergy Project Insulation - (Total Cost: 4930)	2024	2,448						39
40	Synergy Project - Millwork - (Total Cost: 28397)	2024	14,098						40
41	Synergy Project Metal Framing - (Total Cost: 67360)	2024	33,443						41
42	Bock Antenna - Cable installation - (Total Cost: 6300)	2023	3,128						42
43	Synergy Project Cabinets - (Total Cost: 37225)	2024	18,481						43
44	Synergy project - accoustical ceiling - (Total Cost: 33125.62)	2024	16,446						44
45	Synergy project - Floor & Wall -Ceramic tile - (Total Cost: 7000)	2024	3,475						45
46	Synergy project - Counters - (Total Cost: 42954)	2024	21,326						46
47	Synergy Project - Controls - (Total Cost: 4992)	2024	2,478						47
48	Synergy project -Doors Frames Hrdware - (Total Cost: 31413.63)	2024	15,596						48
49	Synergy project - Electrical contractor- (Total Cost: 125672)	2024	62,393						49
50	Synergy project - Fire protection -FireAlmsys - (Total Cost: 14052	2024	6,976						50
51	Synergy Project -general - (Total Cost: 488785.59)	2024	242,670						51
52	Synergy project - HVAC - (Total Cost: 44750)	2024	22,217						52
53	Synergy project - plumbing -Piping - (Total Cost: 143611.26)	2024	71,299						53
54	Signa Rama - Signage throughout int- (Total Cost: 30372.24)	2023	15,079						54
55	Synergy Project Toilets - (Total Cost: 3791)	2024	1,882						55
56	Synergy project - Paint - (Total Cost: 284815)	2024	141,404						56
57	S&R -sealcoating parking lot -AsphaltPav - (Total Cost: 15643)	2024	7,766						57
58	Sebert Landscaping - entire community -Trees - (Total Cost: 2856	2023	14,181						58
59									59
60	Apostrophe' Design - LVP Flooring (\$1,850)	2025	919						60
61	Apostrophe' Design - LVP Flooring (\$6,255)	2025	3,106						61
62	Synergy Construction - Island (\$19,366)	2025	9,615						62
63	Zentel Tech - Chiller Pump Motors (\$23,535)	2024	11,685						63
64	Low Voltage - Cabling Upgrade (\$109,245)	2025	54,240						64
65	Zentel Tech - Kitchen MAU Compressor (\$8,023)	2025	3,983						65
66	Berry Electric - Breakroom Lighting (\$1,773)	2025	880						66
67	Low Voltage Solutions - Chapel AV Sys (\$19,093)	2024	9,480						67
68	Zentel Tech - AHU2 supply fan (\$14,688)	2024	7,293						68
69	Zentel Tech - RTU Supply Fan (\$6,970)	2024	3,461						69
70	TOTAL (lines 4 thru 69)		\$ 11,852,114	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,852,114	\$		\$	\$	\$	1
2	Zentel Tech - Kitchen MAU Controller (\$1,481)	2024	735						2
3	Onward Technologies - Phone Switches (\$6,553)	2025	3,253						3
4	Berry Electric - Lighting (\$21,400)	2025	10,625						4
5									5
6									6
7									7
8									8
9	Depreciation			496,264		496,264		8,441,203	9
10									10
11	Alloc - FSCSC (Page 6A)					10,575	10,575		11
12	Non-Allowable HO Allocation					(4,008)	(4,008)		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,866,727	\$ 496,264		\$ 502,831	\$ 6,567	\$ 8,441,203	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	\$ 916,296	\$	\$	\$		\$	71
72	Current Year Purchases	112,403						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,028,699	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2007	\$ 2,289	\$	\$	\$		\$	76
77	Facility	Bus	2016	34,151						77
78	Facility (TC = \$66,703)	Bus	2018	33,116						78
79	Facility (TC = \$3,790)	Repairs to Facility Vehicles	2023	1,882						79
80	TOTALS			\$ 71,438	\$	\$	\$		\$	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)	\$ 13,107,900	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 496,264	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 502,831	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,567	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,441,203	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Assets - PY Total	\$ 13,133,197	\$	\$	86
87	Non-Care Assets - CY	230,413			87
88					88
89					89
90	Depreciation		302,873	8,035,681	90
91	TOTALS	\$ 13,363,610	\$ 302,873	\$ 8,035,681	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

If NO, see instructions.

YES

XNO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Alloc - FSCSC				10,912			6
7	TOTAL				\$10,912			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

XNO
16. Rental Amount for movable equipment: \$77,004

Description: See Attached and IL/AL Allocation

(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.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$	5,575	\$ 430,684	\$	5,575	\$ 430,684	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		1,961	151,469		1,961	151,469	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		6,429	496,655		6,429	496,655	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3 / 2	# of prescrpts			12,475	415,154		427,629	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Senior Rehab	39-3				638			638	12
13	Other (specify): Lab/Radiology/Oxygen	39-3 / 2				36,099	13,071		49,170	13
14	TOTAL			\$	13,965	\$ 1,128,020	\$ 428,225	13,965	\$ 1,556,245	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	\$ 2,401	\$	1
2	Cash-Patient Deposits	15,585		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 371,005)	1,156,194		3
4	Supply Inventory (priced at)	41,784		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,879		6
7	Other Prepaid Expenses	101,072		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,370,915	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	290,802		13
14	Buildings, at Historical Cost	22,660,029		14
15	Leasehold Improvements, at Historical Cost	52,522		15
16	Equipment, at Historical Cost	979,740		16
17	Accumulated Depreciation (book methods)	(14,451,161)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Deferred Marketing</u>)	9,700		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,541,632	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,912,547	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 211,043	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	96,384		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,126		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,261		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	28,769		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached TB</u>	82,559		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 574,142	\$	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)	\$ 574,142	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,338,405	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,912,547	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,428,016	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,428,016	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,421,465)	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) PY Adjustments	1,331,854	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (89,611)	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)	\$ 10,338,405	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	\$ 15,244,265	1
2	Discounts and Allowances for all Levels	(11,169,671)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,074,594	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,743,829	6
7	Oxygen	13,315	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,757,144	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	8,274	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	436,154	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,192	19
20	Radiology and X-Ray	17,010	20
21	Other Medical Services	387,533	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 859,163	23
	D. Non-Operating Revenue		
24	Contributions	5,600	24
25	Interest and Other Investment Income***	4,114	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,714	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	52,990	27
28	See Attached Schedule	3,249,159	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,302,149	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,002,764	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,388,162	31
32	Health Care	4,463,964	32
33	General Administration	2,560,320	33
	B. Capital Expense		
34	Ownership	865,899	34
	C. Ancillary Expense		
35	Special Cost Centers	5,034,371	35
36	Provider Participation Fee	111,513	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,424,229	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,421,465)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,421,465)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 166,999.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	285,895.00	45
46	MMAI-Medicaid is the Primary Payer	210,523.00	46
47	MMAI-Medicare is the Primary Payer	251,331.00	47
48	Private Pay	2,577,201.00	48
49	Medicare Part A	4,588,054.00	49
50	Other-(specify) Managed Care	1,261,801.00	50
51	Other-(specify) C/A Ancillary	-5,267,276.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,074,528	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	1,284	1,445	\$ 93,670	\$ 64.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,529	24,566	1,057,058	43.03	3
4	Licensed Practical Nurses	6,445	6,816	272,422	39.97	4
5	CNAs & Orderlies	48,786	54,322	1,426,492	26.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	921	987	30,335	30.73	9
10	Activity Assistants	3,303	3,481	67,014	19.25	10
11	Social Service Workers	3,130	3,335	139,262	41.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,463	2,713	73,803	27.20	17
18	Housekeepers	5,973	6,630	126,509	19.08	18
19	Laundry					19
20	Administrator	1,770	1,983	146,734	74.00	20
21	Assistant Administrator					21
22	Other Administrative	4,686	5,064	188,728	37.27	22
23	Office Manager	1,801	2,081	67,154	32.27	23
24	Clerical	6,219	6,694	122,772	18.34	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	3,214	3,609	86,501	23.97	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Mkt, AL/IL</u>	47,920	53,332	1,466,951	27.51	33
34	TOTAL (lines 1 - 33)	160,444	177,058	\$ 5,365,405 *	\$ 30.30	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly fee	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly fee	4,177	10-3	38
39	Pharmacist Consultant	monthly fee	15,336	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	monthly fee	2,036	12-3	45
46	Other(specify)				46
47	<u>Organist/Clergy</u>	monthly fees	11,004	12-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,553		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	10,420	\$ 662,546	10-3	50
51	Licensed Practical Nurses	798	47,666	10-3	51
52	Certified Nurse Assistants/Aides	2,022	70,407	10-3	52
53	TOTAL (lines 50 - 52)	13,240	\$ 780,619		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
LaDon Harris	Executive Director		\$ 146,734
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 146,734
B. Administrative - Other			
Description			Amount
Franciscan Sisters of Chicago Service Corp.			\$ 618,591
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 618,591
C. Professional Services			
Vendor/Payee	Type		Amount
McVey	Legal		\$ 3,214
Lang Technologies	Consulting		872
Inovalon Provider Inc	Consulting		879
Plante Moran	Audit/Cost Report		11,935
Settlement - Folowosele	Legal		55,000
Alloc - AL/IL			(20,851)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 51,049
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 91,136
Unemployment Compensation Insurance			25,927
FICA Taxes			409,584
Employee Health Insurance			313,437
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Disability			10,547
Life Insurance			12,084
Retirement Benefits			75,177
Alloc - FSCSC (Page 6A)			182,610
Alloc - AL/IL HO			(55,039)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,065,463
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			19,051
Health Care Worker Background Check (Indicate # of checks performed 296)			2,956
Patient Background Checks			
Association Dues (total from pg 22, #4)			9,166
Facility Licenses			2,413
Dues and Subscriptions			13,827
Alloc - AL/IL HO			(1,255)
Alloc - FSCSC (Page 6A)			5,526
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 51,684
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			5,279
Alloc - FSCSC (Page 6A)			19,907
Alloc - AL/IL HO			(4,521)
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 20,665

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name

LEADING AGE

Amount

9,166

9,166

Total

(3)

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

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

LEADING AGE

Total

(4)

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

LEADING AGE

9,166

9,166

Total

(5)

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

\$

14,308

Line

10-2

(6)

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

Yes

If NO, attach a complete explanation.

(7)

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

\$

111,513

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?

Yes

Indicate the amount.

\$

1,386

(12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$

N/A

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

Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

Yes

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:

CLA

(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?

Yes

See page 39 of the instructions for details.

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