

		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: 0035006

Facility Name: St Patricks Residence

Address: 1400 Brookdale RoadNaperville60563

County: DuPage

Telephone Number: 630-416-6565Fax # 630-416-8755

HFS ID Number:

Date of Initial License for Current Owners: 05/22/1989

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Rachel KingTelephone Number: 563-484-3819
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 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)

(Type or Print Name) Kate Marrero

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title) Matt LarshSigning Director

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 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	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,095	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	365	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	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	10,988	19,535			3,532	5,736	22,037	61,828	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	10,988	19,535			3,532	5,736	22,037	61,828	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 80.66%

D. How many bed reserve days during this year were paid by the Department? 0 (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 05/22/1989

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/22/1989 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 206

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number St Patricks Residence # 0035006 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	809,170	66,336	9,792	885,298		885,298		885,298			1
2	Food Purchase		616,871		616,871		616,871		616,871			2
3	Housekeeping	634,585	70,079	347	705,011		705,011		705,011			3
4	Laundry	8,011	16,967		24,978		24,978		24,978			4
5	Heat and Other Utilities			403,905	403,905		403,905	(6,789)	397,116			5
6	Maintenance	298,150		170,072	468,222		468,222		468,222			6
7	Other (specify):*											7
8	TOTAL General Services	1,749,916	770,253	584,116	3,104,285		3,104,285	(6,789)	3,097,496			8
	B. Health Care and Programs											
9	Medical Director			36,535	36,535		36,535		36,535			9
10	Nursing and Medical Records	8,847,463	285,866	873,384	10,006,713		10,006,713		10,006,713			10
10a	Therapy	99,883		721,332	821,215		821,215		821,215			10a
11	Activities	242,613	15,458	1,970	260,041		260,041		260,041			11
12	Social Services	215,761	4,265	56,250	276,276		276,276		276,276			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,405,720	305,589	1,689,471	11,400,780		11,400,780		11,400,780			16
	C. General Administration											
17	Administrative	171,735		366,596	538,331		538,331	(366,596)	171,735			17
18	Directors Fees											18
19	Professional Services			85,731	85,731		85,731		85,731			19
20	Dues, Fees, Subscriptions & Promotions			178,387	178,387		178,387	(88,373)	90,014			20
21	Clerical & General Office Expenses	458,167	136,291	1,390,982	1,985,440		1,985,440	(398,213)	1,587,227			21
22	Employee Benefits & Payroll Taxes			2,315,302	2,315,302		2,315,302		2,315,302			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,562	3,562		3,562		3,562			24
25	Other Admin. Staff Transportation			6,717	6,717		6,717		6,717			25
26	Insurance-Prop.Liab.Malpractice			372,543	372,543		372,543		372,543			26
27	Other (specify):*											27
28	TOTAL General Administration	629,902	136,291	4,719,820	5,486,013		5,486,013	(853,182)	4,632,831			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,785,538	1,212,133	6,993,407	19,991,078		19,991,078	(859,971)	19,131,107			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			991,259	991,259		991,259		991,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			265,779	265,779		265,779		265,779			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			120,119	120,119		120,119		120,119			35
36	Other (specify):*											36
37	TOTAL Ownership			1,377,157	1,377,157		1,377,157		1,377,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		361,626	244,326	605,952		605,952		605,952			39
40	Barber and Beauty Shops		29,996		29,996		29,996		29,996			40
41	Coffee and Gift Shops		8,744		8,744		8,744	(8,744)				41
42	Provider Participation Fee			1,271,626	1,271,626		1,271,626		1,271,626			42
43	Other (specify):* Development	62,306		133,879	196,185		196,185	(196,185)				43
44	TOTAL Special Cost Centers	62,306	400,366	1,649,831	2,112,503		2,112,503	(204,929)	1,907,574			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	11,847,844	1,612,499	10,020,395	23,480,738		23,480,738	(1,064,900)	22,415,838			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	(6,789)	5		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	(25,017)	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	(4,372)	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	(336,677)	21		24
25	Fund Raising, Advertising and Promotional	(88,373)	20		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	(237,076)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (698,304)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (698,304)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Coffee/Gift Shop Expense	(8,744)	41	3
4	Investment Fees	(32,147)	21	4
5	Development Salaries	(62,306)	43	5
6	Fundraising/Special Events Expense	(133,879)	43	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				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	(237,076)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[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
Carmelite Sisters for the Aged and Infirm, Inc.	100			Carmelite Sisters For the Aged and Infirm, Inc.	Germantown, NY	Religious Order

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	17	Management Fees	\$ 366,596	Carmelite System	0.00%	\$	(366,596)	1
2	V	21	Administrative - Sisters Stipend	135,807	Carmelite Sisters	0.00%	135,807		2
3	V	12	Pastoral Care - Sisters	56,100	Carmelite Sisters	0.00%	56,100		3
4	V	22	Sisters Medical, Dental, Pension	41,806	Carmelite Sisters	0.00%	41,806		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			\$ 600,309			\$ 233,713	\$ * (366,596)	14

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

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 Patricks Residence # 0035006 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	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										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	Key Bank		X	Renovation	No	11/17/20	\$ 4,765,000	\$ 4,482,078	12/01/45	6.4000	\$ 265,779	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,765,000	\$ 4,482,078			\$ 265,779	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,765,000	\$ 4,482,078			\$ 265,779	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		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				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 Patricks Residence

COUNTY

DuPage

FACILITY IDPH LICENSE NUMBER

0035006

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.		\$	\$
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: **118,218** B. General Construction Type: Exterior **CMV Block & Brick** Frame **Pre-cast concrete** Number of Stories **3**

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

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

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

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

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

H. Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? **No**

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES ☐ NO ☒ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	319,295		1987		\$ 638,590	
2							
3	TOTALS	319,295				\$ 638,590	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	209		1989	1989	\$ 7,786,645	\$		\$	\$	\$	4
5			1997	1997	2,194,676						5
6			2000	2000	2,986,981						6
7			2005	2005	882,594						7
8											8
	Improvement Type**										
9	1991 Fixed Assets			1991	4,862						9
10	1993 Fixed Assets			1993	6,887						10
11	1994 Fixed Assets			1994	31,612						11
12	1996 Fixed Assets			1996	2,976						12
13	1997 Fixed Assets			1997	52,566						13
14	1998 Fixed Assets			1998	28,215						14
15	1999 Fixed Assets			1999	6,832						15
16	2000 Fixed Assets			2000	16,581						16
17	2001 Fixed Assets			2001	10,440						17
18	2002 Fixed Assets			2002	3,966						18
19	2005 Fixed Assets			2005	10,924						19
20	2006 Fixed Assets			2006	237,917						20
21	2007 Fixed Assets			2007	185,440						21
22	2008 Fixed Assets			2008	240,356						22
23	2009 Fixed Assets			2009	59,316						23
24	2010 Fixed Assets			2010	54,416						24
25	2011 Fixed Assets			2011	139,614						25
26	2012 Fixed Assets			2012	84,044						26
27	2013 Fixed Assets			2013	45,901						27
28	2014 Fixed Assets			2014	52,957						28
29	2015 Fixed Assets			2015	108,056						29
30	Crowthers Roofing			2016	3,940						30
31	Chase Ink AV Ovrhd Door			2016	1,775						31
32	Reliant electric Relocation Circuit emergency			2016	3,960						32
33	Showalter Roofing (May & July)			2016	7,535						33
34	Nuyen industries Canope employee entrance			2016	8,250						34
35	Noland Sales Corp lobby & hall vinyl plank flooring			2016	27,809						35
36				2016	1,775						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 Patricks Residence

0035006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NC Concrete Co.Asphalt replacement	2016	\$ 8,340	\$		\$	\$	\$	37
38	Ashland Door - Main Diningroom Doors	2017	603						38
39	Ashland Door - Bring maintenance doors up to code	2017	1,220						39
40	Showalter Roofing Services - Convent Roof	2017	1,199						40
41	Key Construction - Replace holding tanks	2017	6,122						41
42	Replacement pump for fire system	2017	685						42
43	Rogers Pump & Sales - Fire pump rebuild	2017	2,903						43
44	Tr from CIP - Cubicle Curtains	2017	2,487						44
45	Gilkerson Masonry Corp - Reseal Convent Masonry	2017	4,400						45
46	Preferred Window and Door - Upgrade sliding doors	2017	6,200						46
47	PH PH Roofing down payment	2017	89,533						47
48	PH Deposit - Replace Patio Door	2017	3,213						48
49	Perkins Eastman Architects - shower upgrade	2017	17,873						49
50	City of Naperville - Shower upgrade	2017	2,227						50
51	Mazur & Son Construction - shower upgrade	2017	349,259						51
52	FSES Survey	2017	3,750						52
53	Perkins Eastman Architects	2017	44,198						53
54	State of Illinois	2017	6,336						54
55	IDPH Plan Review (construction for bathrooms)	2017	5,992						55
56	Shower Upgrade	2017	250,744						56
57	Argueta's Landscaping - Staff Patio Project	2018	1,140						57
58	Ashland Door - Replace Patio Door	2018	3,123						58
59	Roofed Right America - Roofing Services	2018	89,533						59
60	Ashland Door - Install Pemko Door Shoes - life safety	2018	2,908						60
61	Jense Hughes - Life Safety Survey & Report	2018	4,000						61
62	Pete's Carpet Service - Office Carpeting	2018	790						62
63	Key Construction Group - Convent Plumbing	2018	2,529						63
64	State Mechanical Services - Chapel Condenser	2018	13,992						64
65	Sound Incorporated - Paging System upgrade	2018	8,475						65
66	Roofed Right America - Roofing Services	2018	82,084						66
67	ILLCO - Convent cold water supply run/piping	2018	2,252						67
68	Peerless Fence - Garden Fence	2018	14,985						68
69	Precision Control Systems - Convent water line	2018	3,110						69
70	TOTAL (lines 4 thru 69)		\$ 16,326,022	\$		\$	\$	\$	70

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

Facility Name & ID Number St Patricks Residence

0035006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 16,326,022	\$		\$	\$	\$	1
2	Garden gate final bill - (Citizens cc)	2018	319						2
3	Sound Incorporated - Paging System upgrade	2018	5,733						3
4	Shower upgrade (from CIP)	2018	121						4
5	Hubert Menu Board	2018	588						5
6	Sound Inc - Paging System upgrades	2019	8,475						6
7	Noland Sales - 3rd floor Flooring	2019	83,205						7
8	Faucets - 3rd floor renovation	2019	219						8
9	Sinks - 3rd floor renovation	2019	250						9
10	Goldseal cabinetry - 3rd floor renovation	2019	4,045						10
11	Constructions specialists -building transition strips-3rd floor reno	2019	524						11
12	Jensen Hughes - Life Safety Survey & Report	2019	4,000						12
13	Inpro - 3rd floor renovation - handrails	2019	190						13
14	Peterson - 3rd floor renovation - Nourishment center construction	2019	6,920						14
15	Peterson - 3rd floor renovation - painting	2019	38,845						15
16	Peterson - 3rd floor renovation - handrails (remove old & install n	2019	26,500						16
17	Hospital grade outlets - life safety	2019	666						17
18	Greenbee - LED project 3rd floor	2019	9,533						18
19	3rd floor renovation - nourishment center (drain and electric)	2019	332						19
20	Sherwin Williams - 3rd floor renovation - paint	2019	818						20
21	Peterson - 3rd floor renovation - handrails & doors	2019	5,825						21
22	Reliant - Med room outlets (5)	2019	1,250						22
23	Twin Bros Paving - parking lot	2019	27,625						23
24	CIP - 3rd floor renovation (cabinets/countertops,	2019	12,812						24
25	furniture/finishes) - common areas (dining/hallways/								25
26	nursing stations)								26
27	Shade Sail Awning System - installed in rear patio of SNF	2020	29,600						27
28	Cooling Tower Repair - steel coating, replace fill, eliminator	2020	24,999						28
29	and air inlet louvers								29
30	FSES Survey - fire safety evaluation system	2020	4,400						30
31	3rd floor renovation - nourishment center (drain and electric)	2020	27,469						31
32	furniture/finishes) - common areas (dining/hallways/								32
33	Plubming Project Mechanical Room - replaced leaking parts (ball	2020	2,333						33
34	TOTAL (lines 1 thru 33)		\$ 16,653,618	\$		\$	\$	\$	34

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

Facility Name & ID Number St Patricks Residence

0035006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 16,653,618	\$		\$	\$	\$	1
2	<u>FSES Survey - Required evaluation of the building to prove it is</u>	2021	4,700						2
3	<u>fire-safe, due to NFPA Standards</u>								3
4	<u>Parking lot lamp pole repair-Beaker One Electric Citizens 6/30</u>	2021	2,145						4
5	<u>AC Cooling Tower repair-Kohlert-Citizens 6/30</u>	2021	470						5
6	<u>FSES Survey - Required evaluation of the building to prove it is</u>	2022	4,800						6
7	<u>fire-safe, due to NFPA Standards</u>								7
8	<u>RK reclass bathroom renovations(unit 418) SH Base free standing</u>	2022	5,000						8
9	<u>wall torino, valve, and trim kit. Includes corner shelf and grab bar</u>								9
10	<u>RK reclass bathroom renovations(unit 410) wall torino, valve,</u>	2022	3,500						10
11	<u>trim kit. Also includes corner shelf, grab bar, and shower rod</u>								11
12	<u>Precision Control Systems - 19 3-way valves</u>	2022	10,909						12
13	<u>Citizens - Exhaust fan</u>	2022	945						13
14	<u>Drendel Concrete - garden patio(east side of courtyard)</u>	2022	27,118						14
15	<u>SPR Common space and room renovation</u>	2023	8,456,070						15
16	<u>Construction to create open concept in common spaces</u>								16
17	<u>Resident room renovations to 166 rooms located on 4 units (2E/2W/3E/3W)</u>								17
18	<u>Design fees, construction documents & construction administration</u>								18
19	<u>Building inspections, Drywall, Painting, Electric</u>								19
20	<u>Plumbing, Floor tile, cabinetry, furniture, TVs, Décor,</u>								20
21	<u>Window coverings, appliances, building inspections</u>								21
22	<u>FSES Survey for SNF building</u>	2023	4,900						22
23	<u>Sewer pipe replacement for garbage disposals in SNF (both inside</u>								23
24	<u>and outside of building)</u>	2024	16,195						24
25	<u>FSES Survey for SNF building</u>	2024	4,900						25
26	<u>Ceilings with EVO lights (lighting system for elevators 1, 2 & 3)</u>	2024	11,888						26
27	<u>45 Replacement screens for building windows</u>	2024	3,825						27
28	<u>Ceilings with EVO lights (lighting system for elevators 1, 2 & 3)</u>	2024	11,887						28
29	<u>Key Bank - Front door of Convent</u>	2024	3,341						29
30	<u>Phoenix Fire System Replace 3 NAC Panels, re-pipe</u>	2025	2,415						30
31									31
32				760,763		760,763		14,359,037	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 25,228,626	\$ 760,763		\$ 760,763	\$	\$ 14,359,037	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,422,201	\$ 227,534	\$ 227,534	\$		\$ 1,424,015	71
72	Current Year Purchases	46,057	2,962	2,962			2,962	72
73	Fully Depreciated Assets	4,743,243					4,743,243	73
74								74
75	TOTALS	\$ 7,211,501	\$ 230,496	\$ 230,496	\$		\$ 6,170,220	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	2001 Dodge Grand Caravan		2004	\$ 12,026	\$	\$	\$	5	\$ 12,026	76
77	2008 Chevy Bus		2007	49,512				10	49,512	77
78	2018 Silverado Pickup		2008	23,591				10	23,591	78
79	Other			14,913				10	14,913	79
80	TOTALS			\$ 100,042	\$	\$	\$		\$ 100,042	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)	\$ 33,178,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 991,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 991,259	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)	\$ 20,629,299	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	CIP	\$ 871,742	92
93			93
94			94
95		\$ 871,742	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

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

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy:

YESXNO

Terms:

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$4,720

Description: See Attached - postage meter and storage

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
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	10A-3	hrs	\$	2,827	\$ 227,226	\$	2,827	\$ 227,226	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,876	50,279		1,876	50,279	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		5,049	441,955		5,049	441,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2, 39-3	# of prescrpts				443,935		443,935	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray, Lab, Ambulance</u>	39-3					162,017		162,017	12
13	Other (specify): <u> </u>									

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	\$1,262,883	\$	1
2	Cash-Patient Deposits	71,650		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance214,410)	1,622,826		3
4	Supply Inventory (priced at cost)	28,398		4
5	Short-Term Investments	329,058		5
6	Prepaid Insurance	46,017		6
7	Other Prepaid Expenses	120,575		7
8	Accounts Receivable (owners or related parties)	20,208		8
9	Other(specify):	203,788		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$3,705,403	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,561,803		12
13	Land	638,590		13
14	Buildings, at Historical Cost	24,942,520		14
15	Leasehold Improvements, at Historical Cost	290,809		15
16	Equipment, at Historical Cost	7,311,543		16
17	Accumulated Depreciation (book methods)	(20,629,299)		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 CIP)	871,742		22
23	Other(specify): Non Resident AR	280,041		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$23,267,749	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$26,973,152	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$617,484	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,650		28
29	Short-Term Notes Payable	143,349		29
30	Accrued Salaries Payable	724,604		30
31	Accrued Taxes Payable (excluding real estate taxes)	88,911		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	Other Liabilities	640,983		36
37	Other Accrued Expenses	508,444		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$2,795,425	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,535,152		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)	\$4,535,152	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$7,330,577	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$19,642,575	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$26,973,152	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,098,620	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,098,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,543,964	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) <u>Rounding</u>	(9)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,543,955	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)	\$ 19,642,575	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Patricks Residence

0035006

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	\$ 22,753,947	1
2	Discounts and Allowances for all Levels	(2,764,999)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,988,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	975,689	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 975,689	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	6,991	12
13	Barber and Beauty Care	33,565	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	6,789	15
16	Rental of Facility Space	133,063	16
17	Sale of Drugs	431,786	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,733	19
20	Radiology and X-Ray	2,080	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 651,007	23
	D. Non-Operating Revenue		
24	Contributions	1,028,769	24
25	Interest and Other Investment Income***	1,159,928	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,188,697	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,220,361	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,220,361	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,024,702	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,104,285	31
32	Health Care	11,400,780	32
33	General Administration	5,486,013	33
	B. Capital Expense		
34	Ownership	1,377,157	34
	C. Ancillary Expense		
35	Special Cost Centers	840,877	35
36	Provider Participation Fee	1,271,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 23,480,738	40
41	Income before Income Taxes (line 30 minus line 40)**	1,543,964	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,543,964	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 2,633,963.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,752,559.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	8,557,678.00	48
49	Medicare Part A	3,191,195.00	49
50	Other-(specify) <u>Other</u>	853,553.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,988,948	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		2,092	\$ 133,680	\$ 63.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses		54,843	2,497,955	45.55	3
4	Licensed Practical Nurses		34,277	1,462,486	42.67	4
5	CNAs & Orderlies		162,173	4,653,803	28.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides		3,224	99,883	30.98	8
9	Activity Director					9
10	Activity Assistants		13,169	242,613	18.42	10
11	Social Service Workers		8,025	215,761	26.89	11
12	Dietician		2,259	82,929	36.71	12
13	Food Service Supervisor		2,008	84,224	41.94	13
14	Head Cook		5,544	150,428	27.13	14
15	Cook Helpers/Assistants		28,298	491,589	17.37	15
16	Dishwashers					16
17	Maintenance Workers		11,888	298,150	25.08	17
18	Housekeepers		32,707	634,585	19.40	18
19	Laundry		447	8,011	17.92	19
20	Administrator		2,091	171,735	82.13	20
21	Assistant Administrator					21
22	Other Administrative		10,988	306,033	27.85	22
23	Office Manager					23
24	Clerical		2,135	57,006	26.70	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		2,094	42,533	20.31	31
32	Other Health C: Admissions		4,378	152,134	34.75	32
33	Other(specify) Marketing		2,160	62,306	28.85	33
34	TOTAL (lines 1 - 33)		384,800	\$ 11,847,844 *	\$ 30.79	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	832	13,998	9-3	36
37	Medical Records Consultant	39	2,832	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		38,209	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	12	1,970	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Quality & Business Development		106,770	21-3	47
48					48
49	TOTAL (lines 35 - 48)	883	\$ 163,779		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,033	\$ 613,719	10-3	50
51	Licensed Practical Nurses	1,266	87,043	10-3	51
52	Certified Nurse Assistants/Aides	776	33,162	10-3	52
53	TOTAL (lines 50 - 52)	9,075	\$ 733,925		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
Kate Marrero	Administrator		\$ 171,735	Workers' Compensation Insurance		\$ 172,646	IDPH License Fee		\$ 2,167
				Unemployment Compensation Insurance		99,247	Advertising: Employee Recruitment		39,767
				FICA Taxes		881,958	Health Care Worker Background Check		
				Employee Health Insurance		929,308	(Indicate # of checks performed 60)		600
				Employee Meals		11,918	Patient Background Checks		400 4,000
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		28,509
				Life & Disability		37,625	Other Dues, Subs		14,971
				Pension/401k		97,976			
				EAP		5,464			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$ 171,735				Onboarding & Education		28,298			
				Gifts		14,196			
				Other Benefits		35,846			
				Tuition		820			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8) \$ 2,315,302			TOTAL (agree to Sch. V, line 20, col. 8) \$ 90,014		
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Carmelite System Dues			\$ 366,596	Description	Line #	Amount	Description		Amount
							Out-of-State Travel	\$	180
							In-State Travel		2,047
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) \$ 366,596									
C. Professional Services				TOTAL \$			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description				Amount		
Nixon Peabody	Legal	\$ 26,855							
Sulaiman Law Group, Ltd.	Legal	7,000							
CLA	Accounting	29,310							
The MCS Group, Inc.	Legal	579							
Key Bank	Legal	16,737							
Gary Ritchey	Legal	5,250							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions) \$ 85,731							Seminar Expense		1,335
							Entertainment Expense	(	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$	3,562

*** 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

LEADING AGE

28,509

28,509 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

28,509

28,509 Total
- (5)

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

\$

96,897

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.

\$

1,271,626

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

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

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

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

No

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

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

\$

No

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (12)

Travel and Transportation

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

Yes

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?

None

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

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.