FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0041046

Facility Name: ASCENSION COR MARIAE VILLAGE

Address: 3300 MARIA LINDEN DR (Number) ROCKFORD (City) 61114 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-877-7416 **Fax #** 815-877-4299

HFS ID Number:

Date of Initial License for Current Owners: 06/01/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: PAULA MILLER **Telephone Number:** 816-596-5608
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 7/1/19 to 6/30/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL GORDON
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) ERIC J. NEIDIG, SENIOR MANAGER
(Firm Name & Address) BRADLEY ASSOCIATES, 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 NONE

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,718	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	61	Sheltered Care (SC)	61	22,326	5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	49,044	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,805	3,362	3,930	13,097	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		9,066		9,066	12
13	DD 16 OR LESS					13
14	TOTALS	5,805	12,428	3,930	22,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.19%

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)
N/A - 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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06-05-95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06-05-95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 73 and days of care provided 2,399

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6-30-20 Fiscal Year: 6-30-20

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		23,030	692,417	715,447		715,447	0	715,447			1
2	Food Purchase		171,797		171,797		171,797	(1,513)	170,284			2
3	Housekeeping	135,068	31,620	12,794	179,482		179,482	3,126	182,608			3
4	Laundry	19,056	4,206	77,291	100,553	0	100,553	0	100,553			4
5	Heat and Other Utilities			324,708	324,708		324,708	1,279	325,987			5
6	Maintenance	105,452	20,556	207,762	333,770		333,770	(91,696)	242,074			6
7	Other (specify):* Pastoral	43,535	5,712	7,894	57,141		57,141	0	57,141			7
8	TOTAL General Services	303,111	256,921	1,322,866	1,882,898	0	1,882,898	(88,804)	1,794,094			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,527,316	134,850	348,537	2,010,703		2,010,703	0	2,010,703			10
10a	Therapy			537,023	537,023		537,023	0	537,023			10a
11	Activities	109,330	3,956	2,823	116,109		116,109	0	116,109			11
12	Social Services	58,274		1,758	60,032		60,032	0	60,032			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):* Supportive/shelter	458,660	86	271	459,017		459,017	(459,017)	0			15
16	TOTAL Health Care and Programs	2,153,580	138,892	890,412	3,182,884	0	3,182,884	(459,017)	2,723,867			16
	C. General Administration											
17	Administrative	153,591		886,142	1,039,733		1,039,733	(886,142)	153,591			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			7,888	7,888		7,888	(3,675)	4,213			19
20	Dues, Fees, Subscriptions & Promotions			30,477	30,477		30,477	(1,118)	29,359			20
21	Clerical & General Office Expenses	162,624	10,101	12,893	185,618		185,618	832,194	1,017,812			21
22	Employee Benefits & Payroll Taxes			646,392	646,392		646,392	(14,662)	631,730			22
23	Inservice Training & Education			1,640	1,640		1,640	0	1,640			23
24	Travel and Seminar			3,451	3,451		3,451	0	3,451			24
25	Other Admin. Staff Transportation			3,307	3,307		3,307	0	3,307			25
26	Insurance-Prop.Liab.Malpractice				0		0	207,043	207,043			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	316,215	10,101	1,592,190	1,918,506	0	1,918,506	133,640	2,052,146			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,772,906	405,914	3,805,468	6,984,288	0	6,984,288	(414,181)	6,570,107			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.

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE #0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			128,798	128,798		128,798	239,891	368,689			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			40,675	40,675		40,675	(11,041)	29,634			32
33	Real Estate Taxes			1,375	1,375		1,375	(1,375)	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			31,613	31,613		31,613	0	31,613			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			202,461	202,461	0	202,461	227,475	429,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			585,755	585,755		585,755	0	585,755			39
40	Barber and Beauty Shops			1,486	1,486		1,486	0	1,486			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			108,601	108,601		108,601	0	108,601			42
43	Other (specify):* **Lab/Radiology**			43,269	43,269		43,269	0	43,269			43
44	**TOTAL Special Cost Centers**	0	0	739,111	739,111	0	739,111	0	739,111			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,772,906	405,914	4,747,040	7,925,860	0	7,925,860	(186,706)	7,739,154			45

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	(1,513)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	218,890	30		9
10	Interest and Other Investment Income	(11,041)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,282)	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	(616,830)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (411,776)		$ 0	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	225,070		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 225,070		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (186,706)		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.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASCENSION COR MARIAE VILLAGE

ID# 0041046

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing	$ (415)	20	1
2	Marketing	(25,281)	21	2
3	Marketing	(1,838)	22	3
4	Supportive Living - Salaries	(458,660)	15	4
5	Supportive Living - Benefits	(29,044)	22	5
6	Supportive Living - Other	(357)	15	6
7	Real Estate Tax	(1,375)	33	7
8	Lobbying	(469)	21	8
9	Miscellaneous Revenue	(1,563)	5	9
10	Miscellaneous Revenue	(97)	21	10
11	Non-Allowable Legal Fees	(3,675)	19	11
12	Insurance Proceeds	(94,056)	6	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**	(616,830)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,513)	0	0	0	0	0	0	0	0	0	0	(1,513)	2
3	Housekeeping	0	3,126	0	0	0	0	0	0	0	0	0	3,126	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,563)	2,842	0	0	0	0	0	0	0	0	0	1,279	5
6	Maintenance	(94,056)	2,360	0	0	0	0	0	0	0	0	0	(91,696)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(97,132)	8,328	0	0	0	0	0	0	0	0	0	(88,804)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(459,017)	0	0	0	0	0	0	0	0	0	0	(459,017)	15
16	**TOTAL Health Care and Programs**	(459,017)	0	0	0	0	0	0	0	0	0	0	(459,017)	16
	C. General Administration													
17	Administrative	0	(886,142)	0	0	0	0	0	0	0	0	0	(886,142)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,675)	0	0	0	0	0	0	0	0	0	0	(3,675)	19
20	Fees, Subscriptions & Promotions	(1,697)	579	0	0	0	0	0	0	0	0	0	(1,118)	20
21	Clerical & General Office Expenses	(25,847)	858,041	0	0	0	0	0	0	0	0	0	832,194	21
22	Employee Benefits & Payroll Taxes	(30,882)	16,220	0	0	0	0	0	0	0	0	0	(14,662)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	207,043	0	0	0	0	0	0	0	0	0	207,043	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(62,101)	195,741	0	0	0	0	0	0	0	0	0	133,640	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(618,250)	204,069	0	0	0	0	0	0	0	0	0	(414,181)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	218,890	21,001	0	0	0	0	0	0	0	0	0	239,891	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,041)	0	0	0	0	0	0	0	0	0	0	(11,041)	32
33	Real Estate Taxes	(1,375)	0	0	0	0	0	0	0	0	0	0	(1,375)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	206,474	21,001	0	0	0	0	0	0	0	0	0	227,475	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(411,776)	225,070	0	0	0	0	0	0	0	0	0	(186,706)	45

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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
Rhonda Anderson	BOD	Ascension Senior Living	Various	Ascension Health	Various	Healthcare System
Brad Partridge	BOD	Presence Our Lady of Victory	Bourbannais	Metro Pharmacy	Various	Pharmacy
Stuart Marcus	BOD	Presence St. Joseph Center	Freeport			
Danny Stricker	BOD	Presence St. Anne Center	Rockford			
Michelle Hereford	BOD	Presence Villa Franciscan	Joliet			
		Presence Heritage Village	Kankakee			
		Presence Maryhaven Nursing & Rehab Center	Glenview			

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Ascension Health		$ 3,126	$ 3,126	1
2	V	5	Utilities		Ascension Health		2,842	2,842	2
3	V	6	Maintenance		Ascension Health		2,360	2,360	3
4	V	17	Administration	886,142	Ascension Health			(886,142)	4
5	V	20	Dues and Fees		Ascension Health		579	579	5
6	V	21	Clerical and General Office		Ascension Health		858,041	858,041	6
7	V	22	Benefits	411,264	Ascension Health		427,484	16,220	7
8	V	26	Insurance		Ascension Health		207,043	207,043	8
9	V	30	Depreciation		Ascension Health		21,001	21,001	9
10	V	32	Interest	817	Ascension Health		817		10
11	V	39	Pharmacy	582,927	Metro Pharmacy		582,927		11
12	V								12
13	V								13
14	Total			$ 1,881,150			$ 2,106,220	$ * 225,070	14

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Presence Nazarethville	Des Plaines				1
2			Presence Resurrection Life Center	Chicago				2
3			Presence Resurrection Nursing & Rehab Center	Park Ridge				3
4			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake				4
5			Presence McAuley Manor	Aurora				5
6			A Merkle C Knipprath Nursing Home	Clifton				6
7			Presence St. Benedict	Niles				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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Ascension Health
Street Address: 12250 Weber Hill Road
City / State / Zip Code: St. Louis, Missouri 6312
Phone Number: (816-596-5608
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Direct Cost	Various	15	$ 64,428	$	Various	$ 3,126	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	2,842	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	2,360	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	579	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	858,041	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	427,484	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	207,043	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	21,001	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	817	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					$ 33,204,518	$ 2,702,670		$ 1,523,293	25

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	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.)**

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 0	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).		$ 0	3
4. Real Estate Tax accrual used for 2020 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.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	1,377	8
	2016	1,359	9
	2017	1,361	10
	2018	1,368	11
	2019	1,362	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASCENSION COR MARIAE VILLAGE COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT PAULA MILLER

TELEPHONE 816-596-5608 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 X 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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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).

F. 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1995	$ 925,000	1
2					2
3	TOTALS			$ 925,000	3

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	89		1995	1995	$ 1,000,000	$ 6,860	54	$ 18,519	$ 11,658	$ 703,953	4
5	63		1997	1997	2,508,246	17,868	52	48,236	30,367	1,303,850	5
6	10		2005	2005	944,355	9,995	35	26,982	16,986	457,594	6
7											7
8											8
	Improvement Type**										
9	Various			1995	35,000		10			35,000	9
10	Various			1996	261,495		15			261,495	10
11	Various			1997	528,604		14			528,604	11
12	Various			1998	174,397	4,969	13	13,415	8,446	149,246	12
13	Various			1999	10,976		6			10,976	13
14	Various			2000	35,515		6			35,515	14
15	Various			2001	52,800		9			52,800	15
16	Various			2002	116,065		10			116,065	16
17	Various			2003	126,562		9			126,562	17
18	Various			2004	103,927		9			103,927	18
19	Various			2005	68,501		11			68,501	19
20	Various			2006	115,365		12			115,365	20
21	Various			2007	48,526	1,498	12	4,044	2,546	45,513	21
22	Various			2008	201,896	5,753	13	15,530	9,777	146,633	22
23	Various			2009	282,197	9,503	11	25,654	16,151	218,341	23
24	Various			2010	113,780	3,832	11	10,344	6,512	99,346	24
25	Various			2011	526,824	13,011	15	35,122	22,111	243,113	25
26	Various			2012	64,411	1,836	13	4,955	3,119	41,865	26
27	Various			2013	46,513	1,436	12	3,876	2,440	29,048	27
28											28
29	CENTER AREA STONE VENEER ON WALLS			2014	22,191	1,174	7	3,170	1,996	19,469	29
30	DIALYSIS DEN CONSTRUCTION			2014	1,938	48	15	129	81	768	30
31	EXERCISE ROOM FLOOR			2014	3,500	86	15	233	147	1,328	31
32	FIRE PANEL ON SHELTERED CARE			2014	3,039	113	10	304	191	1,844	32
33	FURNISHING/DECOR FOR FAMILY AND LIVING			2014	19,411	479	15	1,294	815	7,783	33
34	MAIN BUILDING WATER HEATER			2014	3,296	122	10	330	208	1,986	34
35	WALK IN SHOWER FOR BISHOP			2014	5,701	211	10	570	359	3,459	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	
37	BACKFLOW VALVE	2015	$ 2,982	$ 74	15	$ 199	$ 125	$ 1,011	37
38	FLOORING FOR REHAB UNIT	2015	41,000	608	25	1,640	1,032	7,927	38
39	HVAC SOFTWARE	2015	17,445	646	10	1,745	1,099	9,305	39
40	INSTALLATION OF LIGHTING EQUIP	2015	4,277	106	15	285	179	1,544	40
41	LIGHTING EQUIPMENT	2015	1,288	32	15	86	54	465	41
42	PLUMBING DIALYSIS BUILDING OUT	2015	13,770	102	50	275	173	1,330	42
43	ROOF REPAIR GARAGE RAMP	2015	2,950	109	10	295	186	1,733	43
44	DIALYSIS DEN CONSTRUCTION	2015	4,400	109	15	293	184	1,393	44
45	BEDSPREADS CUBICLE CURTAINS	2015	2,436	0	4	0		2,436	45
46	TRANSPORT RECLINERS	2015	7,547	140	20	377	237	2,221	46
47									47
48	Emergency transfer switch	2016	34,508	639	20	1,725	1,086	6,469	48
49	FURNISH/INSTALL TEKNOFLOR - 1st Floor & Bathrooms	2016	24,425	452	20	1,221	769	5,495	49
50	OPTIMA WHITE FLUSH DOOR - 1st Floor	2016	7,565	140	20	378	238	1,702	50
51	REPAIR CONCRETE - Loading Dock	2016	13,575	252	20	679	427	3,055	51
52									52
53	New electrical service install - Dialysis Den	2017	7,240	179	15	483	304	1,449	53
54	CABINET INSTALLATION - Dialysis Den	2017	2,122	52	15	141	89	388	54
55	Dialysis Den Architectural	2017	12,838	317	15	856	539	2,568	55
56	Dialysis Den renovation (plumping)	2017	9,462	234	15	631	397	1,945	56
57	Dialysis Den renovationReq 20 (walls, floors)	2017	16,324	403	15	1,088	685	3,264	57
58	DOOR REPLACEMENTS - Dialysis Den	2017	11,130	275	15	742	467	2,597	58
59	Room demolition & fire rated exit - Dialysis Den	2017	7,378	182	15	492	310	1,517	59
60	ASPHALT MILL & RESURFACE - Parking Lot	2017	54,813	2,030	10	5,481	3,451	14,159	60
61									61
62	Fire alarm panel replacement	2019	7,946	295	10	795	500	1,590	62
63	Parking lot lighting	2019	11,842	292	15	789	497	1,578	63
64	Emergency generator repairs	2019	3,267	242	5	653	411	1,306	64
65	Generator control boards	2019	8,264	612	5	1,653	1,041	3,306	65
66	Roof replacement	2019	42,477	787	20	2,124	1,337	4,248	66
67	Fire Panel	2019	8,598	319	10	860	541	1,720	67
68	Water Heater	2019	11,449	424	10	1,145	721	2,290	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,818,349	$ 88,847		$ 239,837	$ 150,990	$ 5,019,960	70

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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		$ 7,818,349	$ 88,847		$ 239,837	$ 150,990	$ 5,019,960	1
2	Chapel Carpet FY 20	2020	4,200	311	5	840	529	840	2
3	Skilled rofing replacement	2020	106,000	3,927	10	10,600	6,673	10,600	3
4	Chapel Ceiling replacement	2020	7,240	268	10	724	456	724	4
5	Fire Panel	2020	25,734	953	10	2,573	1,620	2,573	5
6	Dehumidifier	2020	23,172	858	10	2,317	1,459	2,317	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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22									22
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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)		$ 7,984,695	$ 95,164		$ 256,891	$ 161,727	$ 5,037,014	34

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 927,882	$ 29,032	$ 78,373	$ 49,341	Various	$ 779,413	71
72	Current Year Purchases	122,738	4,602	12,424	7,822	Various	12,424	72
73	Fully Depreciated Assets	1,632,606			0		1,632,606	73
74	Home Office Allocation		21,001	21,001	0			74
75	TOTALS	$ 2,683,226	$ 54,635	$ 111,798	$ 57,163		$ 2,424,443	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	PLANT ENGINEERING	2000 FORD ELDORADO CAP	2000	$ 42,500	$	$	$ 0	10	$ 42,500	76
77	PLANT ENGINEERING	2013 CHEVROLET SILVER RA	2014	38,730			0	4	38,730	77
78							0			78
79							0			79
80	TOTALS			$ 81,230	$ 0	$ 0	$ 0		$ 81,230	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)	$ 11,674,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 149,799	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 368,689	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 218,890	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,542,687	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 31,613 Description: Nursing - $26,101; Admin - $2,378; Therapy - $2,609; Maintenance - $525
(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.

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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
   - [X] 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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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.)

	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	$		$ 277,306	$		$ 277,306	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			35,863			35,863	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			221,582	2,272		223,854	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	# of prescrpts				585,755		585,755	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 534,751	$ 588,027		$ 1,122,778	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.

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,898	$ 8,136,692	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	535,002	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,339	1,976,078	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	345,314	93,121,433	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 891,553	$ 147,419,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		745,000	11
12	Long-Term Investments		170,652,019	12
13	Land	2,759,592	84,567,210	13
14	Buildings, at Historical Cost	969,491	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	261,780	111,043,559	16
17	Accumulated Depreciation (book methods)	(280,667)	(228,817,338)	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):			22
23	Other(specify): Miscellaneous Assets		11,647,941	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,710,196	$ 636,045,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,601,749	$ 783,464,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 457,797	$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,215	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	74,369	13,740,734	30
31	Accrued Taxes Payable (excluding real estate taxes)		122,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,400	1,115,678	32
33	Accrued Interest Payable			33
34	Deferred Compensation		46,484,006	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to third parties	49,651	4,954,006	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 648,432	$ 237,245,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		180,846,178	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 180,846,178	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 648,432	$ 418,091,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,953,317	$ 365,643,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,601,749	$ 783,734,338	48

***(See instructions.)**

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,136,584	1
2	Restatements (describe):		2
3	Adj. to reconcile	1,971,630	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,108,214	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,154,897)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,154,897)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,953,317	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,484,048	1
2	Discounts and Allowances for all Levels	(1,920,854)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,563,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	951,465	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 951,465	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	395,960	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,686	13
14	Non-Patient Meals	1,513	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	738,297	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,140,456	23
	D. Non-Operating Revenue		
24	Contributions	7,206	24
25	Interest and Other Investment Income***	11,041	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,247	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Insurance Proceeds**	94,056	28
28a	**Miscellaneous**	3,545	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 97,601	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,770,963	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,882,898	31
32	Health Care	3,182,884	32
33	General Administration	1,918,506	33
	B. Capital Expense		
34	Ownership	202,461	34
	C. Ancillary Expense		
35	Special Cost Centers	630,510	35
36	Provider Participation Fee	108,601	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,925,860	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,154,897)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,154,897)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 681,930	44
45	Private Pay - Net Inpatient Revenue	1,773,606	45
46	Medicare - Net Inpatient Revenue	606,204	46
47	Other-(specify)	501,454	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,563,194	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	509	575	$ 41,687	$ 72.50	1
2	Assistant Director of Nursing	476	575	21,158	36.80	2
3	Registered Nurses	18,601	20,740	826,822	39.87	3
4	Licensed Practical Nurses	17,799	19,604	566,061	28.87	4
5	CNAs & Orderlies	28,668	32,036	530,249	16.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,543	1,709	37,969	22.22	9
10	Activity Assistants	4,542	5,328	71,361	13.39	10
11	Social Service Workers	1,974	2,270	58,274	25.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,016	4,291	105,452	24.58	17
18	Housekeepers	8,721	9,386	135,068	14.39	18
19	Laundry	1,454	1,554	19,056	12.26	19
20	Administrator	1,824	2,160	155,209	71.86	20
21	Assistant Administrator					21
22	Other Administrative	288	323	5,437	16.83	22
23	Office Manager	1,505	1,683	33,510	19.91	23
24	Clerical	3,172	3,439	49,818	14.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Admissions	3,103	3,404	72,240	21.22	32
33	Other(specify) Pastoral	1,515	1,860	43,535	23.41	33
34	TOTAL (lines 1 - 33)	99,710	110,937	$ 2,772,906 *	$ 25.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	24	1,724	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,929	11, 3	44
45	Social Service Consultant	24	1,758	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	$ 5,411		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,556	$ 70,340	10, 3	50
51	Licensed Practical Nurses	580	39,102	10, 3	51
52	Certified Nurse Assistants/Aides	7,034	176,420	10, 3	52
53	TOTAL (lines 50 - 52)	9,170	$ 285,862		53

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gillihan	Administrator		$ 153,591
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,591

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 886,142
TOTAL (agree to Schedule V, line 17, col. 3)	$ 886,142
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening, Inc	HR Services	$ 4,213
Non-Allowable Legal Fees	Non-Allowable Legal Fees	3,675
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 7,888

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	212,783
Employee Health Insurance	296,311
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	5,969
Life Insurance	2,559
Disability Insurance	12,651
AH Savings Plan	80,683
Other benefits	35,436
Misc Adjustments - Non-allowable staff	(30,882)
Home Office Allocation	16,220
TOTAL (agree to Schedule V, line 22, col.8)	$ 631,730

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 53)	
Patient Background Checks 161	
Dues and subscriptions	30,477
Home Office Allocation	579
Less: Public Relations Expense	( )
Non-allowable advertising	(1,697)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,359

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,451
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,451

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASCENSION COR MARIAE VILLAGE # 0041046 Report Period Beginning: 7/1/19 Ending: 6/30/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LEADING AGE - $7,816**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **13**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **17,175** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **108,601**
This amount is to be recorded on line 42 of Schedule V.

(12) 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.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **YES - ASSISTED LIV** 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.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **NONE** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **1,513**

(16) 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 fo
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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
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**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **EY - PERFORMS CONSOLIDATED AUDIT OF ASCENSION HEALTH**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees