FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0044784

Facility Name: ASCENSION SAINT BENEDICT

Address: 6930 WEST TOUHY AVE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: 847-647-0003 Fax # 847-647-1936

HFS ID Number:

Date of Initial License for Current Owners: 03-01-00

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 SAINT BENEDICT # 0044784 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	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	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	6,461	13,135	7,693	27,289	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		6,392		6,392	12
13	DD 16 OR LESS					13
14	TOTALS	6,461	19,527	7,693	33,681	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.89%

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 03-01-00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03-01-00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 5,806

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 SAINT BENEDICT # 0044784 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		48,891	717,953	766,844		766,844	0	766,844			1
2	Food Purchase		212,896		212,896		212,896	(1,971)	210,925			2
3	Housekeeping	190,035	44,027	6,203	240,265		240,265	4,070	244,335			3
4	Laundry	83,299		9,435	92,734	0	92,734	(8,631)	84,103			4
5	Heat and Other Utilities			187,590	187,590		187,590	3,700	191,290			5
6	Maintenance	73,806	4,620	163,896	242,322		242,322	3,072	245,394			6
7	Other (specify):* Pastoral	44,671		4,320	48,991		48,991	0	48,991			7
8	TOTAL General Services	391,811	310,434	1,089,397	1,791,642	0	1,791,642	240	1,791,882			8
	B. Health Care and Programs											
9	Medical Director	18,504			18,504		18,504	0	18,504			9
10	Nursing and Medical Records	2,869,840	205,559	131,298	3,206,697		3,206,697	0	3,206,697			10
10a	Therapy	164		1,081,650	1,081,814		1,081,814	0	1,081,814			10a
11	Activities	131,626	3,937	2,933	138,496		138,496	0	138,496			11
12	Social Services	86,042			86,042		86,042	0	86,042			12
13	CNA Training				0		0	0	0			13
14	Program Transportation	28,512			28,512		28,512	(5,808)	22,704			14
15	Other (specify):* Supportive/Shelter	112,023			112,023		112,023	(112,023)	0			15
16	TOTAL Health Care and Programs	3,246,711	209,496	1,215,881	4,672,088	0	4,672,088	(117,831)	4,554,257			16
	C. General Administration											
17	Administrative	137,209		1,280,666	1,417,875		1,417,875	(1,280,666)	137,209			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			11,840	11,840		11,840	(11,730)	110			19
20	Dues, Fees, Subscriptions & Promotions			22,323	22,323		22,323	(742)	21,581			20
21	Clerical & General Office Expenses	179,641	14,689	12,894	207,224		207,224	1,083,349	1,290,573			21
22	Employee Benefits & Payroll Taxes			904,771	904,771		904,771	(44,382)	860,389			22
23	Inservice Training & Education			102	102		102	0	102			23
24	Travel and Seminar			1,768	1,768		1,768	0	1,768			24
25	Other Admin. Staff Transportation			144	144		144	0	144			25
26	Insurance-Prop.Liab.Malpractice			120	120		120	320,110	320,230			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	316,850	14,689	2,234,628	2,566,167	0	2,566,167	65,939	2,632,106			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,955,372	534,619	4,539,906	9,029,897	0	9,029,897	(51,652)	8,978,245			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 SAINT BENEDICT #0044784 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			115,026	115,026		115,026	252,595	367,621			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			106,691	106,691		106,691	(599)	106,092			32
33	Real Estate Taxes			8,010	8,010		8,010	(8,010)	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			26,279	26,279		26,279	0	26,279			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			256,006	256,006	0	256,006	243,986	499,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			771,753	771,753		771,753	0	771,753			39
40	Barber and Beauty Shops			722	722		722	0	722			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			182,947	182,947		182,947	0	182,947			42
43	Other (specify):* **Lab / Radiology**			43,554	43,554		43,554	0	43,554			43
44	**TOTAL Special Cost Centers**	0	0	998,976	998,976	0	998,976	0	998,976			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,955,372	534,619	5,794,888	10,284,879	0	10,284,879	192,334	10,477,213			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 SAINT BENEDICT # 0044784 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	(1,971)	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	(8,631)	4		8
9	Non-Straightline Depreciation	225,255	30		9
10	Interest and Other Investment Income	(599)	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	(8,855)	19		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	(188,510)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 16,689		$ 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)	175,645	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 175,645		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 192,334		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 SAINT BENEDICT

ID# 0044784

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Revenue	$ (11,981)	21	1
2	Miscellaneous Revenue	(5,808)	14	2
3	Fund Raising, Advertising, and Promotional	(1,281)	20	3
4	Fund Raising, Advertising, and Promotional	(34,364)	21	4
5	Fund Raising, Advertising, and Promotional	(2,704)	22	5
6	Real Estate Taxes	(8,010)	33	6
7	Non-Allowable Legal Fees	(2,875)	19	7
8	Lobbying Offset	(785)	21	8
9	State and Local Taxes	(215)	20	9
10	Supportive Living - Salaries	(112,023)	15	10
11	Supportive Living - Benefits	(8,464)	22	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**	(188,510)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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	(1,971)	0	0	0	0	0	0	0	0	0	0	(1,971)	2
3	Housekeeping	0	4,070	0	0	0	0	0	0	0	0	0	4,070	3
4	Laundry	(8,631)	0	0	0	0	0	0	0	0	0	0	(8,631)	4
5	Heat and Other Utilities	0	3,700	0	0	0	0	0	0	0	0	0	3,700	5
6	Maintenance	0	3,072	0	0	0	0	0	0	0	0	0	3,072	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,602)	10,842	0	0	0	0	0	0	0	0	0	240	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	(5,808)	0	0	0	0	0	0	0	0	0	0	(5,808)	14
15	Other (specify):*	(112,023)	0	0	0	0	0	0	0	0	0	0	(112,023)	15
16	**TOTAL Health Care and Programs**	(117,831)	0	0	0	0	0	0	0	0	0	0	(117,831)	16
	C. General Administration													
17	Administrative	0	(1,280,666)	0	0	0	0	0	0	0	0	0	(1,280,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,730)	0	0	0	0	0	0	0	0	0	0	(11,730)	19
20	Fees, Subscriptions & Promotions	(1,496)	754	0	0	0	0	0	0	0	0	0	(742)	20
21	Clerical & General Office Expenses	(47,130)	1,130,479	0	0	0	0	0	0	0	0	0	1,083,349	21
22	Employee Benefits & Payroll Taxes	(11,168)	(33,214)	0	0	0	0	0	0	0	0	0	(44,382)	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	320,110	0	0	0	0	0	0	0	0	0	320,110	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(71,524)	137,463	0	0	0	0	0	0	0	0	0	65,939	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(199,957)	148,305	0	0	0	0	0	0	0	0	0	(51,652)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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	225,255	27,340	0	0	0	0	0	0	0	0	0	252,595	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(599)	0	0	0	0	0	0	0	0	0	0	(599)	32
33	Real Estate Taxes	(8,010)	0	0	0	0	0	0	0	0	0	0	(8,010)	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	216,646	27,340	0	0	0	0	0	0	0	0	0	243,986	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)	16,689	175,645	0	0	0	0	0	0	0	0	0	192,334	45

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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 Health Senior Care	Various	Ascension Health	Various	Healthcare System
Brad Partridge	BOD	Presence Our Lady of Victory	Bourbonnais	Metro Pharmacy	Various	Pharmacy
Stuart Marcus	BOD	Presence Cor Mariae Center	Rockford			
Danny Stricker	BOD	Presence St. Joseph Center	Freeport			
Michelle Hereford	BOD	Presence St. Anne Center	Rockford			
		Presence Villa Franciscan	Joliet			
		Presence Heritage Village	Kankakee			

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		$ 4,070	$ 4,070	1
2	V	5	Utilities		Ascension Health		3,700	3,700	2
3	V	6	Maintenance		Ascension Health		3,072	3,072	3
4	V	17	Administration	1,280,666	Ascension Health			(1,280,666)	4
5	V	20	Dues and Fees		Ascension Health		754	754	5
6	V	21	Clerical and General Office		Ascension Health		1,130,479	1,130,479	6
7	V	22	Benefits	575,385	Ascension Health		542,171	(33,214)	7
8	V	26	Insurance		Ascension Health		320,110	320,110	8
9	V	30	Depreciation		Ascension Health		27,340	27,340	9
10	V	32	Interest	40,913	Ascension Health		40,913		10
11	V	39	Pharmacy	770,137	Metro Pharmacy		770,137		11
12	V								12
13	V								13
14	Total			$ 2,667,101			$ 2,842,746	$ * 175,645	14

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

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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 Maryhaven Nursing & Rehab Center	Glenview				1
2			Presence Nazarethville	Des Plaines				2
3			Presence Resurrection Life Center	Chicago				3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge				4
5			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake				5
6			Presence McAuley Manor	Aurora				6
7			A Merkle C Knipprath Nursing Home	Clifton				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 SAINT BENEDICT # 0044784 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 SAINT BENEDICT # 0044784 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 63127
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	$ 4,070	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	3,700	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	3,072	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	754	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	1,130,479	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	542,171	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	320,110	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	27,340	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	40,913	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		$ 2,072,609	25

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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 SAINT BENEDICT # 0044784 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.**	$	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		8
	2016		9
	2017		10
	2018		11
	2019		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 SAINT BENEDICT COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

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 _____ 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 SAINT BENEDICT # 0044784 Report Period Beginning: 7/1/19 Ending: 6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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	56,961	2000	$ 2,910,262	1
2					2
3	TOTALS	56,961		$ 2,910,262	3

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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	99		2000	1991	$ 5,342,488	$ 45,149	40	$ 133,562	$ 88,413	$ 2,940,853	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	92,057	0	7	0		92,057	9
10	VARIOUS			2001	273,061	0	12	0		273,061	10
11	VARIOUS			2002	29,538	0	16	0		29,538	11
12	VARIOUS			2003	8,200	77	15	227	150	8,200	12
13	VARIOUS			2004	12,982	292	15	865	573	12,076	13
14	VARIOUS			2005	191,740	0	10	0		191,740	14
15	VARIOUS			2006	86,586	0	10	0		86,586	15
16	VARIOUS			2008	1,284	22	20	64	42	801	16
17	VARIOUS			2012	15,524	228	23	675	447	5,361	17
18											18
19	REMOVING TOP 2 inch OF ASPHALT			2014	50,900	2,151	8	6,363	4,212	37,823	19
20	RENOVATIONS FOR CONVERSION OF			2014	50,400	852	20	2,520	1,668	14,993	20
21	REPLACE AIR COOLED CHILLER MOD			2014	125,000	2,113	20	6,250	4,137	37,246	21
22											22
23	: DEPOSIT TO INSTALL NEW LIGHT			2015	6,477	110	20	324	214	1,539	23
24	BARIATRIC BED, ELECTRONIC, WID			2015	6,884	129	18	382	253	2,026	24
25	BARIATRIC POWERED ALTERNATING			2015	9,997	188	18	555	367	2,401	25
26											26
27	NEW Bathroom - (ILC) Independent Living			2016	9,350	158	20	468	310	1,910	27
28	: Electrical work for new phone system			2016	3,335	56	20	167	111	737	28
29	: INSTALL RESILIENT FLOORING - (ILC) Independent Living			2016	7,494	127	20	375	248	1,687	29
30	NEW CARRIER MAKE UP AIR			2016	60,000	1,014	20	3,000	1,986	10,750	30
31	New window			2016	3,525	59	20	176	117	631	31
32	GALVANIZED STEEL INSULATD DOOR			2016	3,635	62	20	182	120	728	32
33	2ND FLOOR CORRIDOR LED LIGHTS			2016	4,318	58	25	173	115	778	33
34	ILC Roof Replacement			2016	78,623	1,329	20	3,931	2,602	15,069	34
35											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 SAINT BENEDICT # 0044784 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	AIR HANDLER	2017	$ 66,112	$ 894	25	$ 2,644	$ 1,750	$ 8,814	37
38	ASPHALT NEW PARKING LOT	2017	98,921	3,344	10	9,892	6,548	25,554	38
39	SKYLIGHT SPINKLER - Front Entrance	2017	3,695	63	20	185	122	509	39
40	FLOOR IN ACTIVITES ROOM	2017	5,925	401	5	1,185	784	3,555	40
41	NEW WINDOW - Independent Living	2017	3,525	59	20	176	117	602	41
42									42
43									43
44	: Basement Sewer Line	2019	20,640	349	20	1,032	683	2,064	44
45	: Boiler Replacement ILC	2019	52,566	888	20	2,628	1,740	5,256	45
46	: Basement Sewer Line	2019	61,174	1,034	20	3,059	2,025	6,118	46
47	Ejector Pumps	2019	20,000	338	20	1,000	662	2,000	47
48	Freezer Door	2019	4,668	158	10	467	309	934	48
49	: Electric Booster Water Hea	2019	24,954	562	15	1,664	1,102	3,328	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,835,577	$ 62,264		$ 184,191	$ 121,927	$ 3,827,325	70

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

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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	$ 1,903,887	$ 49,821	$ 147,390	$ 97,569	Various	$ 1,674,346	71
72	Current Year Purchases	84,240	2,941	8,700	5,759	Various	8,700	72
73	Fully Depreciated Assets	696,551			0		696,551	73
74	Home Office Allocation		27,340	27,340	0			74
75	TOTALS	$ 2,684,678	$ 80,102	$ 183,430	$ 103,328		$ 2,379,597	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				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	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)	$ 12,430,517	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 142,366	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 367,621	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 225,255	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,206,922	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 SAINT BENEDICT # 0044784 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: $ 26,279 Description: Nursing 24,084; Admin 2,163; Spiritual Care 32.
(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 SAINT BENEDICT # 0044784 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	2	3	4
		Facility			
		Drop-outs	Completed	Contract	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	$		$ 483,326	$		$ 483,326	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			147,369			147,369	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			448,141	2,814		450,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				771,753		771,753	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			$		$ 1,078,836	$ 774,567		$ 1,853,403	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 SAINT BENEDICT # 0044784 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	$ 177	$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,045,764	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,454	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	734,781	93,121,433	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,815,176	$ 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	3,468,000	84,567,210	13
14	Buildings, at Historical Cost	2,122,064	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	194,401	111,043,559	16
17	Accumulated Depreciation (book methods)	(248,175)	(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): Misc Assets		11,647,941	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,536,290	$ 636,045,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,351,466	$ 783,464,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 849,268	$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	174,301	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	171,511	13,470,734	30
31	Accrued Taxes Payable (excluding real estate taxes)		122,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,165	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	1,975	4,954,006	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,206,220	$ 236,975,122	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)**	$ 1,206,220	$ 417,821,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,145,246	$ 365,643,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,351,466	$ 783,464,338	48

*(See instructions.)

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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**	$ 6,295,804	1
2	Restatements (describe):		2
3	Adj to Reconcile	(1,181,116)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,114,688	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,030,558	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,030,558	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)**	$ 6,145,246	24 *

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

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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	$ 8,919,902	1
2	Discounts and Allowances for all Levels	(1,107,570)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,812,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,973,343	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,973,343	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	493,103	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,989	13
14	Non-Patient Meals	1,971	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,004,244	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	8,631	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,511,938	23
	D. Non-Operating Revenue		
24	Contributions	2,375	24
25	Interest and Other Investment Income***	599	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,974	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	14,850	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,850	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,315,437	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,791,642	31
32	Health Care	4,672,088	32
33	General Administration	2,566,167	33
	B. Capital Expense		
34	Ownership	256,006	34
	C. Ancillary Expense		
35	Special Cost Centers	816,029	35
36	Provider Participation Fee	182,947	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,284,879	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,030,558	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,030,558	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,195,603	44
45	Private Pay - Net Inpatient Revenue	4,330,771	45
46	Medicare - Net Inpatient Revenue	1,923,196	46
47	Other-(specify) Insurance	362,762	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,812,332	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 SAINT BENEDICT # 0044784 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	455	549	$ 39,076	$ 71.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,504	39,511	1,674,089	42.37	3
4	Licensed Practical Nurses	5,654	6,480	186,207	28.74	4
5	CNAs & Orderlies	54,532	62,507	1,034,189	16.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3	3	164	54.67	8
9	Activity Director	2,066	2,234	68,270	30.56	9
10	Activity Assistants	4,342	4,974	63,357	12.74	10
11	Social Service Workers	3,396	3,911	86,042	22.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,924	4,687	102,318	21.83	17
18	Housekeepers	11,252	12,537	190,035	15.16	18
19	Laundry	4,982	5,856	83,299	14.22	19
20	Administrator	1,708	1,843	137,209	74.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,974	4,239	54,442	12.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	130	130	18,504	142.34	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,755	2,069	48,305	23.35	31
32	Other Health C: Admissions	3,764	4,339	125,195	28.85	32
33	Other(specify) Pastoral	1,428	1,618	44,671	27.61	33
34	TOTAL (lines 1 - 33)	138,869	157,487	$ 3,955,372 *	$ 25.12	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				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,984	74,576	10, 3	52
53	TOTAL (lines 50 - 52)	2,984	$ 74,576		53

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristen Felker	Administrator		$ 137,209
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,209

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,280,666
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,280,666
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening, Inc	HR Services	$ 110
Non-Allowable Legal Fees	Non-Allowable Legal Fees	2,875
Non-Allowable Marketing	Non-Allowable Marketing	8,855
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 11,840

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	300,881
Employee Health Insurance	466,313
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	10,668
Life Insurance	3,452
Disability	36,023
Pension	68,788
Tuition Reimbursement	
Other Benefits	18,646
Home Office Allocation & Marketing Offset	(44,382)
TOTAL (agree to Schedule V, line 22, col.8)	$ 860,389

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 10)	
Patient Background Checks 327	
Dues & Subscriptions	20,827
Home Office Allocation	754
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,768
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,768

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASCENSION SAINT BENEDICT # 0044784 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 - $13,079**

(3) Did the nursing home make political contributions or payments to a political 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? **15 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,198** 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 for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **182,947**
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 to the Department, in addition to the daily rate, been properly classified 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 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.

(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. $ **1,971**

(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 for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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 other 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 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