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: 0041871

Facility Name: ASCENSION SAINT JOSEPH VILLAGE

Address: 659 E JEFFERSON ST (Number) FREEPORT (City) 61032 (Zip Code)

County: STEPHENSON

Telephone Number: 815-232-6181 **Fax #** 815-232-6143

HFS ID Number:

Date of Initial License for Current Owners: 07-01-96

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 JOSEPH VILLAGE # 0041871 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	124	Skilled (SNF)	124	45,384	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,384	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	19,576	8,513	3,893	31,982	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,576	8,513	3,893	31,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.47%

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 07-01-96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07-01-96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 2,633

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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 JOSEPH VILLAGE # 0041871 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		38,383	618,100	656,483		656,483		656,483			1
2	Food Purchase		227,620		227,620		227,620	(34,259)	193,361			2
3	Housekeeping	148,099	23,547		171,646		171,646	3,760	175,406			3
4	Laundry		5,088	90,704	95,792		95,792	(3,815)	91,977			4
5	Heat and Other Utilities			153,524	153,524		153,524	3,418	156,942			5
6	Maintenance	149,098	40,757	177,155	367,010		367,010	2,838	369,848			6
7	Other (specify):* Pastoral	51,446	1,192	3,837	56,475		56,475		56,475			7
8	**TOTAL General Services**	348,643	336,587	1,043,320	1,728,550		1,728,550	(28,058)	1,700,492			8
	B. Health Care and Programs											
9	Medical Director	11,338			11,338		11,338		11,338			9
10	Nursing and Medical Records	2,883,282	131,951	183,573	3,198,806		3,198,806	(20)	3,198,786			10
10a	Therapy			408,756	408,756		408,756		408,756			10a
11	Activities	105,522	497	2,720	108,739		108,739		108,739			11
12	Social Services	77,694		1,040	78,734		78,734		78,734			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,077,836	132,448	596,089	3,806,373		3,806,373	(20)	3,806,353			16
	C. General Administration											
17	Administrative	169,033		1,021,091	1,190,124		1,190,124	(1,021,091)	169,033			17
18	Directors Fees											18
19	Professional Services			1,677	1,677		1,677		1,677			19
20	Dues, Fees, Subscriptions & Promotions			26,613	26,613		26,613	(655)	25,958			20
21	Clerical & General Office Expenses	123,711	60,421	26,640	210,772		210,772	977,125	1,187,897			21
22	Employee Benefits & Payroll Taxes			978,868	978,868		978,868	(66,638)	912,230			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,274	1,274		1,274		1,274			24
25	Other Admin. Staff Transportation			2,375	2,375		2,375		2,375			25
26	Insurance-Prop.Liab.Malpractice							338,045	338,045			26
27	Other (specify):*											27
28	**TOTAL General Administration**	292,744	60,421	2,058,538	2,411,703		2,411,703	226,786	2,638,489			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,719,223	529,456	3,697,947	7,946,626		7,946,626	198,708	8,145,334			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 JOSEPH VILLAGE #0041871 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			172,978	172,978		172,978	282,045	455,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,815	46,815		46,815	(2,446)	44,369			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,684	20,684		20,684		20,684			35
36	Other (specify):*											36
37	**TOTAL Ownership**			240,477	240,477		240,477	279,599	520,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			984,621	984,621		984,621		984,621			39
40	Barber and Beauty Shops			3,515	3,515		3,515		3,515			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,523	251,523		251,523		251,523			42
43	Other (specify):* **Lab/Radiology**			27,808	27,808		27,808		27,808			43
44	**TOTAL Special Cost Centers**			1,267,467	1,267,467		1,267,467		1,267,467			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,719,223	529,456	5,205,891	9,454,570		9,454,570	478,307	9,932,877			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 JOSEPH VILLAGE # 0041871 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	(34,259)	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	256,788	30		9
10	Interest and Other Investment Income	(2,446)	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	(10,838)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,352)	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	(61,385)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 146,508		$	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)	331,799	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 331,799		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 478,307		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 JOSEPH VILLAGE

ID# 0041871

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Revenue	$ (1,434)	21	1
2	IDPH Fine	(30)	21	2
3	Fund Raising, Advertising, and Promotional	(51,862)	21	3
4	Fund Raising, Advertising, and Promotional	(3,696)	22	4
5	Laundry Revenue	(3,815)	4	5
6	Medical Records	(20)	10	6
7	Lobbying	(528)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(61,385)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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	(34,259)	0	0	0	0	0	0	0	0	0	0	(34,259)	2
3	Housekeeping	0	3,760	0	0	0	0	0	0	0	0	0	3,760	3
4	Laundry	(3,815)	0	0	0	0	0	0	0	0	0	0	(3,815)	4
5	Heat and Other Utilities	0	3,418	0	0	0	0	0	0	0	0	0	3,418	5
6	Maintenance	0	2,838	0	0	0	0	0	0	0	0	0	2,838	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(38,074)	10,016	0	0	0	0	0	0	0	0	0	(28,058)	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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(20)	0	0	0	0	0	0	0	0	0	0	(20)	16
	C. General Administration													
17	Administrative	0	(1,021,091)	0	0	0	0	0	0	0	0	0	(1,021,091)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,352)	697	0	0	0	0	0	0	0	0	0	(655)	20
21	Clerical & General Office Expenses	(64,692)	1,041,817	0	0	0	0	0	0	0	0	0	977,125	21
22	Employee Benefits & Payroll Taxes	(3,696)	(62,942)	0	0	0	0	0	0	0	0	0	(66,638)	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	338,045	0	0	0	0	0	0	0	0	0	338,045	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(69,740)	296,526	0	0	0	0	0	0	0	0	0	226,786	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,834)	306,542	0	0	0	0	0	0	0	0	0	198,708	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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 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)	
	D. Ownership													
30	Depreciation	256,788	25,257	0	0	0	0	0	0	0	0	0	282,045	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,446)	0	0	0	0	0	0	0	0	0	0	(2,446)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	254,342	25,257	0	0	0	0	0	0	0	0	0	279,599	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)**	146,508	331,799	0	0	0	0	0	0	0	0	0	478,307	45

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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. 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		$ 3,760	$ 3,760	1
2	V	5	Utilities		Ascension Health		3,418	3,418	2
3	V	6	Maintenance		Ascension Health		2,838	2,838	3
4	V	17	Administration	1,021,091	Ascension Health			(1,021,091)	4
5	V	20	Dues and Fees		Ascension Health		697	697	5
6	V	21	Clerical and General Office		Ascension Health		1,041,817	1,041,817	6
7	V	22	Benefits	678,137	Ascension Health		615,195	(62,942)	7
8	V	26	Insurance		Ascension Health		338,045	338,045	8
9	V	30	Depreciation		Ascension Health		25,257	25,257	9
10	V	32	Interest	1,633	Ascension Health		1,633		10
11	V	39	Pharmacy	984,252	Metro Pharmacy		984,252		11
12	V								12
13	V								13
14	Total			$ 2,685,113			$ 3,016,912	$ * 331,799	14

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

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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 SAINT JOSEPH VILLAGE # 0041871 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 JOSEPH VILLAGE # 0041871 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	$ 3,760	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	3,418	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	2,838	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	697	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	1,041,817	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	615,195	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	338,045	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	25,257	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	1,633	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		$ 2,032,660	25

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 JOSEPH VILLAGE # 0041871 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).		$	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.		$	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 JOSEPH VILLAGE COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

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	$	$

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 JOSEPH VILLAGE # 0041871 Report Period Beginning: 7/1/19 Ending: 6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

Presence Saint Vincent - Hoban Hall; Community Living Facility; 9,252 Sq Ft; 20 Beds.
Presence Saint Joseph ADC - O'Neil Hall; Adult Day Care Center; 17,437 Sq Ft; N/A Beds.
Sacred Heart Chapel; Chapel; 5,194 Sq Ft; N/A Beds.
Presence Saint Vincent SLA - Trinity House; Supportive Living Arrangement; 3,041 Sq Ft; N/A Beds (Unlicensed).
Presence Saint Vincent SLA - Bidwell House; Supportive Living Arrangement; 1,279 Sq Ft; N/A Beds (Unlicensed).
Presence Saint Vincent SLA - Rectory House; Supportive Living Arrangement; 1,120 Sq Ft; N/A Beds (Unlicensed).

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	603,713	1996	$ 1,400,000	1
2					2
3	TOTALS	603,713		$ 1,400,000	3

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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	120		1996	1996	$ 2,500,000	$ 18,986	53	$ 47,170	$ 28,184	$ 1,367,456	4
5	10		2013	2013	3,148,390	36,206	35	89,954	53,748	646,070	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698		13			78,698	11
12	VARIOUS			2001	19,599		10			19,599	12
13	VARIOUS			2002	28,056		13			28,056	13
14	VARIOUS			2003	77,639		11			77,639	14
15	VARIOUS			2004	16,330		10			16,330	15
16	VARIOUS			2005	93,561	3,138	12	7,797	4,659	91,794	16
17	VARIOUS			2006	47,671		10			47,671	17
18	VARIOUS			2007	163,794	5,071	13	12,600	7,529	138,825	18
19	VARIOUS			2008	197,106	5,667	14	14,079	8,412	195,132	19
20	VARIOUS			2009	153,368	5,144	12	12,781	7,637	140,035	20
21	VARIOUS			2010	128,973	2,916	10	7,245	4,329	128,973	21
22	VARIOUS			2011	39,476	1,589	10	3,948	2,359	35,335	22
23	VARIOUS			2012	9,244	286	13	711	425	6,350	23
24	VARIOUS			2013	507,163	17,011	12	42,264	25,253	186,959	24
25											25
26	ADD CELL PHONE CAPABILITY			2014	2,972	120	10	297	177	2,038	26
27	CEILING TILES FOR OCEANVIEW			2014	2,846	115	10	285	170	1,953	27
28	COMPRESSOR FOR CARRIER CONDENS			2014	5,090	171	12	424	253	2,545	28
29	CONTRACT LABOR MATERIAL AND EQ			2014	9,251	465	8	1,156	691	6,782	29
30	DESIGN BUILD INSTALL HIGH ALTA			2014	3,774	101	15	252	151	1,517	30
31	DOOR ENTRANCE STORM			2014	6,855	184	15	457	273	3,159	31
32	FIRE ALARM SYSTEM MODIFICATION			2014	2,735	44	25	109	65	760	32
33	FIRE DOORS			2014	2,828	57	20	141	84	980	33
34	GENERATOR			2014	4,700	158	12	392	234	2,330	34
35	NEW BOILER			2014	22,230	448	20	1,112	664	6,693	35
36	PARKING LOT			2014	9,750	147	5	364	217	9,750	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 JOSEPH VILLAGE # 0041871 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	NORTH ROOF OF ONEILL H	2014	$ 11,850	$ 477	10	$ 1,185	$ 708	$ 6,985	37
38	TUCKPOINTING ADC CHAPEL	2014	9,700	56	70	139	83	831	38
39									39
40	AIR COND. CONDENSING UNIT FOR SUNSHINE COURT	2015	26,832	1,080	10	2,683	1,603	12,968	40
41	DOOR ALARMS WEST UNIT	2015	2,740	110	10	274	164	1,416	41
42	CIRCUIT BREAKER AND WIRING NODES FOR BUILDING	2015	10,514	212	20	526	314	2,410	42
43	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	2,674	43	25	107	64	562	43
44	LIGHTING EQUIP. FOR RESIDENT ROOMS AND HALLWAY	2015	11,017	295	15	734	439	3,977	44
45	COUNTERTOP/SINKS/TOILETS/STALLS FOR MENS ROOM	2015	13,691	276	20	685	409	3,709	45
46	ROOF REPAIR ADC BLDG	2015	71,175	2,865	10	7,118	4,253	34,995	46
47	ROOFTOP HEATING AC UNIT	2015	3,746	43	35	107	64	638	47
48	WALK-IN TUB, TILE AND MIRROR FOR BATHROOM IN CL	2015	10,337	208	20	517	309	3,070	48
49	WINDOW REPLACEMENT CLF	2015	3,380	68	20	169	101	915	49
50	YORK ROOF TOP	2015	11,140	448	10	1,114	666	5,941	50
51	CIRCLE DRIVE PROJECT	2015	1,400	28	20	70	42	327	51
52	PARKING LOT PROJECT	2015	5,000	101	20	250	149	1,167	52
53	NURSE STATION UPGRADE	2015	1,660	33	20	83	50	394	53
54									54
55	: FURNISH AND INSTALL NEW 4" Piping & RPZ Backflow	2016	8,203	220	15	547	327	2,005	55
56	New Network Control Engine	2016	4,150	84	20	208	124	866	56
57	FIRE SPRINKLER WORK/SKYLIGHTS	2016	3,940	79	20	197	118	887	57
58	FRONT ENTRY PLASTER WORK	2016	2,073	56	15	138	82	622	58
59	NURSE STATION UPGRADE	2016	820	17	20	41	24	185	59
60									60
61	ADC Roof Replacement	2017	5,250	141	15	350	209	1,138	61
62	Natural Gas Line Replacement	2017	28,377	762	15	1,892	1,130	5,346	62
63	STJ/ADC New Floor	2017	14,155	380	15	944	564	2,777	63
64	Therapy Room Renovation - Flooring & Walls	2017	26,848	720	15	1,790	1,070	5,348	64
65									65
66	NURSE STATION UPGRADE	2018	4,320	174	10	432	258	960	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,581,847	$ 106,999		$ 265,838	$ 158,838	$ 3,348,623	70

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

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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		$ 7,581,847	$ 106,999		$ 265,838	$ 158,838	$ 3,348,623	1
2	Parking Lot Repairs Concrete	2018	35,000	704	20	1,750	1,046	1,750	2
3	Contract Labor Material and Eq	2018	7,500	151	20	375	224	375	3
4	Canopy Project	2018	29,000	584	20	1,450	866	1,450	4
5	Reshape Existing Stone Asphalt	2018	19,500	392	20	975	583	975	5
6									6
7	REPLACING FAILING WINDOWS	2019	3,268	88	15	218	130	436	7
8	GARBAGE DISPOSAL	2019	2,624	211	5	525	314	1,050	8
9	Progressive Flow Twin Replacement of Water Softener	2019	10,325	416	10	1,033	617	2,066	9
10	DOMESTIC HOT WATER	2019	87,500	1,761	20	4,375	2,614	8,750	10
11	Re-frame opening and install flooring for nursing station	2019	20,046	538	15	1,336	798	2,672	11
12	FURNISH/INSTALL 2 COMPRESSORS,	2019	27,560	1,109	10	2,756	1,647	5,512	12
13	BUNDLED FIRE HYDRANT AND INSTALLATION	2019	10,930	440	10	1,093	653	2,186	13
14	SEWER REPLACEMENT	2019	32,420	522	25	1,297	775	2,594	14
15	Replace frame and walls, new flooring for women's bathroom	2019	20,057	538	15	1,337	799	2,674	15
16	TWO AC UNITS PER QUOTE	2019	64,360	2,590	10	6,436	3,846	12,872	16
17	PARKING LOT REPAIR SOUTH	2019	49,995	1,342	15	3,333	1,991	6,666	17
18	Insulating Steam Pipes	2019	12,650	339	15	843	504	843	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,014,582	$ 118,724		$ 294,970	$ 176,245	$ 3,401,494	34

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

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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 12B, Carried Forward		$ 8,014,582	$ 118,724		$ 294,970	$ 176,245	$ 3,401,494	1
2	Flooring - Resident Rooms	2020	46,780	3,766	5	9,356	5,590	9,356	2
3	Install SHAW LVT flooring and dumawall tiles	2020	6,986	562	5	1,397	835	1,397	3
4	to walls of resident bathroom								4
5	Breakroom Flooring	2020	2,462	198	5	492	294	492	5
6	Chapel Entrance Ramp	2020	4,136	167	10	414	247	414	6
7	Chapel Storm Windows	2020	23,950	482	20	1,198	716	1,198	7
8	Close East Chapel Entrance	2020	8,007	161	20	400	239	400	8
9	Chapel Exterior Wall	2020	58,632	1,180	20	2,932	1,752	2,932	9
10	Bathroom Night Lights	2020	5,081	409	5	1,016	607	1,016	10
11	Chapel Ceiling Fans & Lights	2020	3,750	302	5	750	448	750	11
12	Exhaust Fan - Boiler Room	2020	3,542	95	15	236	141	236	12
13	AC Unit - Kitchen	2020	19,364	520	15	1,291	771	1,291	13
14	Privacy Wall for Generator	2020	12,275	247	20	614	367	614	14
15	Fire Panel	2020	22,975	925	10	2,298	1,373	2,298	15
16	Nurse Call Electric Circuit	2020	8,316	335	10	832	497	832	16
17	Conduit for Phone Lines	2020	3,200	129	10	320	191	320	17
18	7/1/19 Capital Rate Adjustments	2020	(242,383)						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,001,655	$ 128,202		$ 318,516	$ 190,313	$ 3,425,040	34

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

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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	$ 1,145,166	$ 35,843	$ 89,055	$ 53,212	Various	$ 827,117	71
72	Current Year Purchases	156,446	8,934	22,197	13,263	Various	22,197	72
73	Fully Depreciated Assets	704,453					704,453	73
74	Home Office Allocation		25,255	25,255				74
75	TOTALS	$ 2,006,065	$ 70,032	$ 136,507	$ 66,475		$ 1,553,767	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	TOTAL			$ 229,693	$	$	$	4	$ 229,693	76
77	SEE VEHICLE ATTACHMENT									77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 229,693	$	$	$		$ 229,693	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)	$ 11,637,413	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 198,234	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 455,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 256,788	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,208,500	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.

	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	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$	$	$	5	$ 24,090	76
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123				3	23,123	77
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275				4	34,275	78
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649				4	15,649	79
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155				4	48,155	79
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232				4	58,232	79
79C	PLANT ENGINEERING	2014 BUICK ENCORE 4WD	2014	26,169				4	26,169	79
80	TOTALS			$ 229,693	$ 404	$ 1,237	$ 833		$ 229,693	80

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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: $ 20,684 Description: Nursing 19,906; Admin 741; Maintenance 37.
(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 JOSEPH VILLAGE # 0041871 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	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	$		$ 163,655	$		$ 163,655	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			27,851			27,851	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			217,149	101		217,250	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				984,621		984,621	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			$		$ 408,655	$ 984,722		$ 1,393,377	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 JOSEPH VILLAGE # 0041871 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	$ 7,430	$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	653,216	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	30,636	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	675,335	93,121,433	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,366,617	$ 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	918,270	84,567,210	13
14	Buildings, at Historical Cost	2,715,685	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	405,432	111,043,559	16
17	Accumulated Depreciation (book methods)	(340,781)	(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)**	$ 3,698,606	$ 636,045,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,065,223	$ 783,464,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,000,691	$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,707	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	131,721	13,470,734	30
31	Accrued Taxes Payable (excluding real estate taxes)		122,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)		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	61,905	4,954,006	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,287,024	$ 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)**	$	$ 180,846,178	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,287,024	$ 417,821,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,778,199	$ 365,643,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,065,223	$ 783,464,338	48

***(See instructions.)**

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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**	$ 3,937,394	1
2	Restatements (describe):		2
3	**Adj to Reconcile**	1,425,184	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,362,578	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,584,379)	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)**	$ (1,584,379)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,778,199	24 *

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

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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	$ 7,279,855	1
2	Discounts and Allowances for all Levels	(1,874,723)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,405,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	844,750	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 844,750	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	194,548	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,703	13
14	Non-Patient Meals	34,259	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,269,833	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)**	$ 1,503,343	23
	D. Non-Operating Revenue		
24	Contributions	107,521	24
25	Interest and Other Investment Income***	2,446	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 109,967	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,999	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,999	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,870,191	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,728,550	31
32	Health Care	3,806,373	32
33	General Administration	2,411,703	33
	B. Capital Expense		
34	Ownership	240,477	34
	C. Ancillary Expense		
35	Special Cost Centers	1,015,944	35
36	Provider Participation Fee	251,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,454,570	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,584,379)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,584,379)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,421,974	44
45	Private Pay - Net Inpatient Revenue	2,029,669	45
46	Medicare - Net Inpatient Revenue	669,197	46
47	Other-(specify) Insurance	284,292	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,405,132	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 JOSEPH VILLAGE # 0041871 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	499	573	$ 33,662	$ 58.75	1
2	Assistant Director of Nursing	324	332	11,622	35.01	2
3	Registered Nurses	22,966	24,933	852,103	34.18	3
4	Licensed Practical Nurses	26,829	28,956	871,936	30.11	4
5	CNAs & Orderlies	66,379	73,145	1,113,959	15.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	2,112	42,399	20.08	9
10	Activity Assistants	4,446	5,054	63,124	12.49	10
11	Social Service Workers	3,644	4,019	77,694	19.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,406	9,208	149,098	16.19	17
18	Housekeepers	10,779	11,902	148,099	12.44	18
19	Laundry					19
20	Administrator	1,824	2,008	169,033	84.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,171	1,326	27,140	20.47	23
24	Clerical	4,038	4,500	63,878	14.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	95	95	11,338	119.35	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	1,784	1,983	32,692	16.49	32
33	Other(specify) Pastoral	1,993	2,127	51,446	24.19	33
34	TOTAL (lines 1 - 33)	157,076	172,273	$ 3,719,223 *	$ 21.59	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	26	1,892	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				44
45	Social Service Consultant	17	1,040	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	43	$ 2,932		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	173	$ 10,917	10	50
51	Licensed Practical Nurses	982	43,134	10	51
52	Certified Nurse Assistants/Aides	687	16,177	10	52
53	TOTAL (lines 50 - 52)	1,842	$ 70,228		53

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 169,033
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,033

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,021,091
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,021,091
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening, Inc	HR Services	$ 1,677
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,677

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	280,470
Employee Health Insurance	558,235
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	15,140
Life Insurance	3,143
Disability	14,394
Pension	64,773
Tuition Reimbursement	4,164
Other Benefits	38,550
Home Office Allocation & Marketing Offset	(66,639)
TOTAL (agree to Schedule V, line 22, col.8)	$ 912,230

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 44)	
Patient Background Checks 260	
Dues & Subscriptions	25,261
Home Office Allocation	697
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,274
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,274

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASCENSION SAINT JOSEPH VILLAGE # 0041871 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 - $8,794**

(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? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,590** 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. $ **251,523**
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. $ **34,259**

(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