

		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: 0044792

Facility Name: ASCENSION CASA SCALABRINI

Address: 480 NORTH WOLF ROAD NORTHLAKE 60164
Number City Zip Code

County: COOK

Telephone Number: 708-562-0040 Fax # 708-562-5180

HFS ID Number:

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

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	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 CASA SCALABRINI

0044792 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	201	Skilled (SNF)	201	73,566	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	229	TOTALS	229	83,814	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	40,175	16,089	8,655	64,919	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,175	16,089	8,655	64,919	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.46%

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 201 and days of care provided 5,677

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 CASA SCALABRINI** # **0044792** 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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		86,345	1,024,845	1,111,190		1,111,190	0	1,111,190			1
2	Food Purchase		438,212		438,212		438,212	(180)	438,032			2
3	Housekeeping	286,960	113,783	2,737	403,480		403,480	7,597	411,077			3
4	Laundry	97,025	38,078	55,984	191,087	0	191,087	(6,111)	184,976			4
5	Heat and Other Utilities			354,272	354,272		354,272	6,906	361,178			5
6	Maintenance	146,967	20,670	457,703	625,340		625,340	5,734	631,074			6
7	Other (specify):* Pastoral	114,815	8,224	3,035	126,074		126,074	0	126,074			7
8	TOTAL General Services	645,767	705,312	1,898,576	3,249,655	0	3,249,655	13,946	3,263,601			8
	B. Health Care and Programs											
9	Medical Director	13,688		36,400	50,088		50,088	0	50,088			9
10	Nursing and Medical Records	6,406,444	500,116	435,250	7,341,810		7,341,810	(105)	7,341,705			10
10a	Therapy	146		1,098,356	1,098,502		1,098,502	0	1,098,502			10a
11	Activities	166,613	8,553	5,608	180,774		180,774	(4,499)	176,275			11
12	Social Services	157,148	79	2,661	159,888		159,888	0	159,888			12
13	CNA Training				0		0	0	0			13
14	Program Transportation			1,225	1,225		1,225	0	1,225			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	6,744,039	508,748	1,579,500	8,832,287	0	8,832,287	(4,604)	8,827,683			16
	C. General Administration											
17	Administrative	141,539		2,171,622	2,313,161		2,313,161	(2,171,622)	141,539			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			8,877	8,877		8,877	(4,107)	4,770			19
20	Dues, Fees, Subscriptions & Promotions			39,191	39,191		39,191	693	39,884			20
21	Clerical & General Office Expenses	368,307	5,918	121,126	495,351		495,351	1,994,405	2,489,756			21
22	Employee Benefits & Payroll Taxes			1,755,467	1,755,467		1,755,467	(127,855)	1,627,612			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			1,235	1,235		1,235	0	1,235			24
25	Other Admin. Staff Transportation			659	659		659	0	659			25
26	Insurance-Prop.Liab.Malpractice			3,806	3,806		3,806	688,426	692,232			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	509,846	5,918	4,101,983	4,617,747	0	4,617,747	379,940	4,997,687			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,899,652	1,219,978	7,580,059	16,699,689	0	16,699,689	389,282	17,088,971			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			352,167	352,167		352,167	590,606	942,773			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			208,670	208,670		208,670	(1,253)	207,417			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			88,712	88,712		88,712	0	88,712			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			649,549	649,549	0	649,549	589,353	1,238,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		158	1,302,443	1,302,601		1,302,601	0	1,302,601			39
40	Barber and Beauty Shops			4,856	4,856		4,856	0	4,856			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			490,534	490,534		490,534	0	490,534			42
43	Other (specify):* Lab/Radiology			11,738	11,738		11,738	0	11,738			43
44	TOTAL Special Cost Centers	0	158	1,809,571	1,809,729	0	1,809,729	0	1,809,729			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,899,652	1,220,136	10,039,179	19,158,967	0	19,158,967	978,635	20,137,602			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(180)	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	(6,111)	4		8
9	Non-Straightline Depreciation	539,574	30		9
10	Interest and Other Investment Income	(1,253)	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	(714)	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	(105,780)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 425,536		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	553,099	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 553,099		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 978,635		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Records Revenue	\$ (105)	10	1
2	Lobbying	(1,122)	21	2
3	Fund Raising, Advertising, and Promotional	(88,076)	21	3
4	Fund Raising, Advertising, and Promotional	(6,451)	22	4
5	Transportation Revenue	(4,499)	11	5
6	Non-Allowable Legal Fees	(4,107)	19	6
7	Vendor Refunds	(1,420)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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24				24
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27				27
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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	(105,780)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION CASA SCALABRINI

0044792

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(180)	0	0	0	0	0	0	0	0	0	0	(180)	2
3	Housekeeping	0	7,597	0	0	0	0	0	0	0	0	0	7,597	3
4	Laundry	(6,111)	0	0	0	0	0	0	0	0	0	0	(6,111)	4
5	Heat and Other Utilities	0	6,906	0	0	0	0	0	0	0	0	0	6,906	5
6	Maintenance	0	5,734	0	0	0	0	0	0	0	0	0	5,734	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,291)	20,237	0	0	0	0	0	0	0	0	0	13,946	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	(105)	0	0	0	0	0	0	0	0	0	0	(105)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,499)	0	0	0	0	0	0	0	0	0	0	(4,499)	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	(4,604)	0	0	0	0	0	0	0	0	0	0	(4,604)	16
	C. General Administration													
17	Administrative	0	(2,171,622)	0	0	0	0	0	0	0	0	0	(2,171,622)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,107)	0	0	0	0	0	0	0	0	0	0	(4,107)	19
20	Fees, Subscriptions & Promotions	(714)	1,407	0	0	0	0	0	0	0	0	0	693	20
21	Clerical & General Office Expenses	(90,618)	2,085,023	0	0	0	0	0	0	0	0	0	1,994,405	21
22	Employee Benefits & Payroll Taxes	(6,451)	(121,404)	0	0	0	0	0	0	0	0	0	(127,855)	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	688,426	0	0	0	0	0	0	0	0	0	688,426	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(101,890)	481,830	0	0	0	0	0	0	0	0	0	379,940	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(112,785)	502,067	0	0	0	0	0	0	0	0	0	389,282	29

Summary B

Facility Name & ID Number

0044792

7/1/19

Ending:

6/30/20

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

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	\$	Ascension Health		\$ 7,597	\$ 7,597	1
2	V	5	Utilities		Ascension Health		6,906	6,906	2
3	V	6	Maintenance		Ascension Health		5,734	5,734	3
4	V	17	Administration	2,171,622	Ascension Health			(2,171,622)	4
5	V	20	Dues and Fees		Ascension Health		1,407	1,407	5
6	V	21	Clerical and General Office		Ascension Health		2,085,023	2,085,023	6
7	V	22	Benefits	1,144,168	Ascension Health		1,022,764	(121,404)	7
8	V	26	Insurance		Ascension Health		688,426	688,426	8
9	V	30	Depreciation		Ascension Health		51,032	51,032	9
10	V	32	Interest	74,591	Ascension Health		74,591		10
11	V	39	Pharmacy	1,295,970	Metro Pharmacy		1,295,970		11
12	V								12
13	V								13
14	Total			\$ 4,686,351			\$ 5,239,450	\$ * 553,099	14

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

Facility Name & ID Number

ASCENSION CASA SCALABRINI

0044792

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 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
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12								12
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28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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 CASA SCALABRINI
--------------------------------------	----------------------------------

0044792

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Direct Cost	Various	15	\$ 64,428	\$	Various	\$ 7,597	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	6,906	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	5,734	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	1,407	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	2,085,023	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	1,022,764	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	688,426	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	51,032	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	74,591	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		\$ 3,943,480	25

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.

2

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

2

3. Under or (over) accrual (line 2 minus line 1).

2

O

4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)

2

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.)

2

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.)
--------------	----	-----	-----------	---

2

6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

2

0

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 CASA SCALABRINI COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044792

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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 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 providecopies of their original second installment tax bill.

A. Square Feet: 195,174

B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	696,960	2000	\$ 1,500,000	1
2					2
3	TOTALS	696,960		\$ 1,500,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	253		2000		\$ 7,510,695	\$ 74,153	40	\$ 187,767	\$ 113,614	\$ 4,546,431
5										
6										
7										
8										
	Improvement Type**									
9	VARIOUS		2000		87,374	0	8	0		87,374
10	VARIOUS		2001		22,045	0	10	0		22,045
11	VARIOUS		2002		2,385	0	10	0		2,385
12	VARIOUS		2004		23,112	457	20	1,156	699	19,042
13	VARIOUS		2005		74,417	0	11	0		74,417
14	VARIOUS		2006		2,077,086	54,685	15	138,472	83,787	1,525,060
15	VARIOUS		2007		87,391	2,157	16	5,462	3,305	82,837
16	VARIOUS		2008		7,411	147	20	371	224	4,615
17	VARIOUS		2012		321,297	9,063	14	22,950	13,887	188,357
18	VARIOUS		2013		867,185	19,026	18	48,177	29,151	297,622
19										
20	33 NEW SMOKE DETECTORS 4 PULL		2014		12,662	250	20	633	383	6,924
21	ARCHITECTURAL SERVICE FOR ALL		2014		46,000	1,211	15	3,067	1,856	18,358
22	INSTALL NEW FLOOR IN WALK IN F		2014		9,050	357	10	905	548	5,471
23	RENOVATION OF QUAD UNITS INTO		2014		638,000	1,680	150	4,253	2,573	169,686
24	RENOVATIONS OF QUAD UNITS INTO		2014		101,261	2,666	15	6,751	4,085	40,894
25	REPLACEMENT OF DOORS IN SEVERA		2014		17,175	452	15	1,145	693	6,870
26	SIDEWALK ADDED FROM THERAPY RO		2014		8,000	210	15	533	323	3,215
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 CASA SCALABRINI

0044792

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	: 3 SHOWER REMODEL UNIT 3	2015	\$ 11,600	\$ 229	20	\$ 580	\$ 351	\$ 2,707	37
38	24 RM CONVERT INTO SHORT TERM	2015	55,467	1,095	20	2,773	1,678	13,173	38
39	24 SEMI PRIV RMS TO 15 PRIV SK	2015	110,934	2,191	20	5,547	3,356	28,659	39
40	BACKUP GENERATOR FIRE PUMP REP	2015	128,500	3,383	15	8,567	5,184	40,692	40
41	CHANGE ORDER REQUEST #3	2015	10,850	214	20	543	329	2,487	41
42	CONVER 24 RMS TO PRIVIATE SNF	2015	5,666	112	20	283	171	1,322	42
43	INSTALL NEW R 22 CARRIER AIR C	2015	41,573	1,095	15	2,772	1,677	16,405	43
44	PHASE 2 NURSE CALL	2015	4,200	83	20	210	127	980	44
45	PHASE 2 OF WING REMODEL AND NU	2015	375,000	7,405	20	18,750	11,345	93,917	45
46	PHASE 2 WING REMODEL NURSE SUB	2015	257,000	5,075	20	12,850	7,775	60,367	46
47	RENOVATE OF QUAD UNITS INTO 15	2015	8,532	169	20	427	258	2,276	47
48	RENOVATIONS OF QUAD UNITS INTO	2015	67,507	1,333	20	3,375	2,042	20,048	48
49	REPLACE KITCHEN FLOOR SINK PIP	2015	8,950	71	50	179	108	880	49
50	SPRINKLER HEAD REPLACE	2015	39,700	1,045	15	2,647	1,602	12,572	50
51									51
52	: A- wings air handler&AC re	2017	44,708	883	20	2,235	1,352	8,196	52
53	: Elevator Repair Hydraulic	2016	7,900	156	20	395	239	1,613	53
54	: INSTALLATION OF NEW Nurse Station Flooring	2016	10,995	289	15	733	444	2,688	54
55	INTERIOR FINISH HANNA Z - Vinyl Flooring Nurse Station	2016	12,951	341	15	863	522	3,812	55
56	PHASE 2 WING REMODEL NURSE Station - Painting	2016	1,750	35	20	88	53	395	56
57	INTERIOR FINISH HANNA Z - Paneling Nurse Station	2016	3,777	100	15	252	152	1,113	57
58	PHASE 2 WING REMODEL NURSE Station Buildout/Constructi	2016	68,870	1,360	20	3,444	2,084	15,467	58
59	PHASE 2 WING REMODEL NURSE Station Buildout/Constructi	2016	22,400	442	20	1,120	678	4,013	59
60									60
61	: A- wings air handler&AC re	2017	134,123	2,648	20	6,706	4,058	23,385	61
62	: Elevator mechanical room controls	2017	13,700	271	20	685	414	2,028	62
63	copper pipe replacement - Boiler Room	2017	8,500	168	20	425	257	1,275	63
64	: Asphalt - Parking Lot	2017	84,370	3,332	10	8,437	5,105	21,796	64
65									65
66	POLE LIGHTS AND BASES - Courtyard Walkway	2017	19,600	387	20	980	593	2,450	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,471,668	\$ 200,426		\$ 507,508	\$ 307,082	\$ 7,486,319	70

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

Facility Name & ID Number ASCENSION CASA SCALABRINI

0044792

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,471,668	\$ 200,426		\$ 507,508	\$ 307,082	\$ 7,486,319	1
2	Gas Line Replacement	2017	16,000	316	20	800	484	800	2
3	Asphalt repairs and Lot Ma	2018	82,500	3,258	10	8,250	4,992	8,250	3
4	Replace Pole Lights and Bases	2018	19,500	385	20	975	590	975	4
5	Replace two fire hydrants at f	2018	19,225	380	20	961	581	961	5
6									6
7	Buy and Install 10 Ton Compressor for Blower Shaft	2019	17,990	355	20	900	545	1,800	7
8	INSTALL CONCRETE SIDEWALK	2019	4,400	116	15	293	177	586	8
9	Fan Coils	2019	45,000	1,777	10	4,500	2,723	9,000	9
10	599 : Window Replacement	2019	120,000	4,739	10	12,000	7,261	24,000	10
11	090518 : VSN Tile Flat Roof Replacement	2019	435,259	6,876	25	17,410	10,534	26,115	11
12	122018 F : Nurse Call Sysytem	2019	16,350	646	10	1,635	989	3,270	12
13	HVAC - Replace 26 Exisiting Fan	2019	74,900	2,958	10	7,490	4,532	7,490	13
14			0	0		0		0	14
15	Dock Ceiling Reapir - 500 Sq Feet	2020	10,560	278	15	704	426	704	15
16	Tuckpinting FY20	2020	24,750	652	15	1,650	998	1,650	16
17	Exit Doors G North	2020	7,124	281	10	712	431	712	17
18	Courtyard Awning	2020	6,656	263	10	666	403	666	18
19	Unit C Dining Room Counter Top	2020	5,400	142	15	360	218	360	19
20	Nurse Call System	2020	19,578	773	10	1,958	1,185	1,958	20
21	Window Replacement	2020	28,800	1,137	10	2,880	1,743	2,880	21
22	Bundled Window Replace GF Building	2020	5,860	231	10	586	355	586	22
23	Nurse Call System	2020	18,502	731	10	1,850	1,119	1,850	23
24	Parking Lot - Replace Front Parking Lot	2020	31,946	841	15	2,130	1,289	2,130	24
25	Cooling Unit Pipes FY20	2020	18,700	492	15	1,247	755	1,247	25
26	7/1/19 Capital Corrections	2020	25,932						26
27	7/1/19 Capital Rate Adjustments	2020	(3,004,336)						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,522,264	\$ 228,053		\$ 577,465	\$ 349,412	\$ 7,584,309	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 4,394,638	\$ 119,251	\$ 301,962	\$ 182,711	Various	\$ 3,597,541	71
72	Current Year Purchases	74,164	4,863	12,314	7,451	Various	12,314	72
73	Fully Depreciated Assets	1,080,958	0		0		1,080,958	73
74	Home Office Allocation		51,032	51,032	0			74
75	TOTALS	\$ 5,549,760	\$ 175,146	\$ 365,308	\$ 190,162		\$ 4,690,813	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	2	
	Reference	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)	\$ 18,572,024	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 403,199	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 942,773	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 539,574	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,275,122	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.

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: *

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: \$88,712 Description: Admin 4,393; Dietary 264; Environmental 40; Therapy 148; Nursing 83,862; Spiritual Care 5.
(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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 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, 1	2	hrs	\$		\$ 443,439	\$	2	\$ 443,439	1
2	Licensed Speech and Language Development Therapist	10a, 3		hrs			100,648			100,648	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 3		hrs			553,096	1,172		554,268	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				1,302,443		1,302,443	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				\$		\$ 1,097,183	\$ 1,303,615	2	\$ 2,400,798	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,439	\$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,143,860	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	47,770	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,442,846	93,121,433	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,657,915	\$ 147,419,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		745,000	11
12	Long-Term Investments		170,652,019	12
13	Land	2,742,271	84,567,210	13
14	Buildings, at Historical Cost	5,061,277	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	1,243,229	111,043,559	16
17	Accumulated Depreciation (book methods)	(732,658)	(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): <u>Misc Assets</u>		11,647,941	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,314,119	\$ 636,045,090	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,972,034	\$ 783,464,338	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,055,252	\$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	186,143	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	483,873	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	<u>Due to Third Parties</u>	338	4,954,006	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,725,606	\$ 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)	\$ 2,725,606	\$ 417,821,300	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,246,428	\$ 365,643,038	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,972,034	\$ 783,464,338	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,653,044	1
2	Restatements (describe):		2
3	Adj to Reconcile	865,104	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,518,148	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,271,720)	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)	\$ (1,271,720)	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)	\$ 9,246,428	24

* This must agree with page 17, line 47.

Facility Name & ID Number ASCENSION CASA SCALABRINI

0044792

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 20,356,828	1
2	Discounts and Allowances for all Levels	(6,592,616)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,764,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,003,763	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,003,763	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	250,429	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,721	13
14	Non-Patient Meals	180	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,839,731	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	6,111	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,104,172	23
	D. Non-Operating Revenue		
24	Contributions	4,244	24
25	Interest and Other Investment Income***	1,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,497	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,603	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,603	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,887,247	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,249,655	31
32	Health Care	8,832,287	32
33	General Administration	4,617,747	33
	B. Capital Expense		
34	Ownership	649,549	34
	C. Ancillary Expense		
35	Special Cost Centers	1,319,195	35
36	Provider Participation Fee	490,534	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,158,967	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,271,720)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,271,720)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,145,939	44
45	Private Pay - Net Inpatient Revenue	3,958,098	45
46	Medicare - Net Inpatient Revenue	1,871,962	46
47	Other-(specify) <u>Insurance</u>	788,213	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,764,212	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	527	567	\$ 54,024	\$ 95.28	1
2	Assistant Director of Nursing	421	567	30,387	53.59	2
3	Registered Nurses	90,234	98,562	4,074,784	41.34	3
4	Licensed Practical Nurses	5,195	5,700	185,475	32.54	4
5	CNAs & Orderlies	112,853	121,759	2,021,052	16.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3	3	146	48.67	8
9	Activity Director	1,152	1,214	27,460	22.62	9
10	Activity Assistants	9,821	10,934	139,153	12.73	10
11	Social Service Workers	6,782	7,763	157,148	20.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,843	6,504	146,967	22.60	17
18	Housekeepers	19,873	22,212	286,960	12.92	18
19	Laundry	6,689	7,723	97,025	12.56	19
20	Administrator	2,008	2,184	141,539	64.81	20
21	Assistant Administrator					21
22	Other Administrative	458	521	14,302	27.45	22
23	Office Manager	950	1,165	30,729	26.38	23
24	Clerical	9,230	10,574	170,696	16.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	195	195	13,688	70.19	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,318	1,592	40,721	25.58	31
32	Other Health C: Admissions	5,036	5,669	152,581	26.91	32
33	Other(specify) Pastoral	3,368	3,799	114,815	30.22	33
34	TOTAL (lines 1 - 33)	281,956	309,207	\$ 7,899,652 *	\$ 25.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				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	8	536	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	\$ 536		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	39	1,678	10	51
52	Certified Nurse Assistants/Aides	11,675	293,246	10	52
53	TOTAL (lines 50 - 52)	11,714	\$ 294,924		53

Facility Name & ID Number ASCENSION CASA SCALABRINI	STATE OF ILLINOIS # 0044792	Report Period Beginning: 7/1/19	Ending: 6/30/20	Page 22
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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 - \$18,701

(3) Did the nursing home make political contributions or payments to a political 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. \$ 107,940 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. \$ 490,534
 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. \$ 180

(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? YES
 See page 39 of the instructions for details. YES
 Attach invoices and a summary of services for all architect and appraisal fees