

		FOR BHF USE					

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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: 0042861 Facility Name: ASCENSION VILLA FRANCISCAN Address: 210 N SPRINGFIELD AV JOLIET 60435 County: WILL Telephone Number: 815-725-3400 Fax # 815-725-2160 HFS ID Number: Date of Initial License for Current Owners: 12-01-97 Type of Ownership: ☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501C3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: PAULA MILLER Telephone Number: 816-596-5608

Email Address:

Facility Name & ID Number ASCENSION VILLA FRANCISCAN

0042861 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	154	Skilled (SNF)	154	56,364	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	154	TOTALS	154	56,364	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	11,805	4,857	17,281	33,943	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,805	4,857	17,281	33,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.22%

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 09-01-90

J. Was the facility purchased or leased after January 1, 1978? YES X Date 12-01-97 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 154 and days of care provided 11,076

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 VILLA FRANCISCAN** # **0042861** 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		53,318	663,446	716,764		716,764	0	716,764			1
2	Food Purchase		229,689		229,689		229,689	(1,850)	227,839			2
3	Housekeeping	174,146	82	1,652	175,880		175,880	5,747	181,627			3
4	Laundry	23,471		78,586	102,057	0	102,057	0	102,057			4
5	Heat and Other Utilities			220,944	220,944		220,944	5,225	226,169			5
6	Maintenance	151,656	39,087	157,516	348,259		348,259	4,338	352,597			6
7	Other (specify):* Pastoral	53,768	591	1,111	55,470		55,470	0	55,470			7
8	TOTAL General Services	403,041	322,767	1,123,255	1,849,063	0	1,849,063	13,460	1,862,523			8
	B. Health Care and Programs											
9	Medical Director	20,000		22,725	42,725		42,725	0	42,725			9
10	Nursing and Medical Records	3,882,407	315,643	820,391	5,018,441		5,018,441	(1,797)	5,016,644			10
10a	Therapy			1,413,443	1,413,443		1,413,443	0	1,413,443			10a
11	Activities	120,998	6,408	16,564	143,970		143,970	0	143,970			11
12	Social Services	128,673	6,138	4,502	139,313		139,313	0	139,313			12
13	CNA Training				0		0	0	0			13
14	Program Transportation			101	101		101	0	101			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	4,152,078	328,189	2,277,726	6,757,993	0	6,757,993	(1,797)	6,756,196			16
	C. General Administration											
17	Administrative	127,085		1,807,693	1,934,778		1,934,778	(1,807,693)	127,085			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			9,898	9,898		9,898	(8,056)	1,842			19
20	Dues, Fees, Subscriptions & Promotions			39,854	39,854		39,854	(1,009)	38,845			20
21	Clerical & General Office Expenses	496,510	12,169	45,328	554,007		554,007	1,480,076	2,034,083			21
22	Employee Benefits & Payroll Taxes			1,246,854	1,246,854		1,246,854	85,319	1,332,173			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			1,508	1,508		1,508	0	1,508			24
25	Other Admin. Staff Transportation			1,823	1,823		1,823	0	1,823			25
26	Insurance-Prop.Liab.Malpractice			120	120		120	372,169	372,289			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	623,595	12,169	3,153,078	3,788,842	0	3,788,842	120,806	3,909,648			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,178,714	663,125	6,554,059	12,395,898	0	12,395,898	132,469	12,528,367			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			215,802	215,802		215,802	413,896	629,698			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			51,752	51,752		51,752	(26,881)	24,871			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			117,758	117,758		117,758	0	117,758			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			385,312	385,312	0	385,312	387,015	772,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			1,424,739	1,424,739		1,424,739	0	1,424,739			39
40	Barber and Beauty Shops			600	600		600	0	600			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			231,921	231,921		231,921	0	231,921			42
43	Other (specify):* Lab/Radiology			114,279	114,279		114,279	0	114,279			43
44	TOTAL Special Cost Centers	0	0	1,771,539	1,771,539	0	1,771,539	0	1,771,539			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,178,714	663,125	8,710,910	14,552,749	0	14,552,749	519,484	15,072,233			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	(1,850)	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	375,289	30		9
10	Interest and Other Investment Income	(26,881)	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	(43)	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	(2,074)	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	(111,869)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 232,572		\$ 0	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	286,912	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 286,912		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 519,484		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	\$(1,797)	10	1
2	Miscellaneous Revenue	(34,756)	21	2
3	Fund Raising, Advertising, and Promotional	(61,497)	21	3
4	Fund Raising, Advertising, and Promotional	(4,787)	22	4
5	Lobbying Offset	(976)	21	5
6	Non-Allowable Legal Fees	(8,056)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(111,869)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION VILLA FRANCISCAN# 0042861

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	(1,850)	0	0	0	0	0	0	0	0	0	0	(1,850)	2
3	Housekeeping	0	5,747	0	0	0	0	0	0	0	0	0	5,747	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,225	0	0	0	0	0	0	0	0	0	5,225	5
6	Maintenance	0	4,338	0	0	0	0	0	0	0	0	0	4,338	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,850)	15,310	0	0	0	0	0	0	0	0	0	13,460	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	(1,797)	0	0	0	0	0	0	0	0	0	0	(1,797)	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	(1,797)	0	0	0	0	0	0	0	0	0	0	(1,797)	16
	C. General Administration													
17	Administrative	0	(1,807,693)	0	0	0	0	0	0	0	0	0	(1,807,693)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,056)	0	0	0	0	0	0	0	0	0	0	(8,056)	19
20	Fees, Subscriptions & Promotions	(2,074)	1,065	0	0	0	0	0	0	0	0	0	(1,009)	20
21	Clerical & General Office Expenses	(97,272)	1,577,348	0	0	0	0	0	0	0	0	0	1,480,076	21
22	Employee Benefits & Payroll Taxes	(4,787)	90,106	0	0	0	0	0	0	0	0	0	85,319	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	372,169	0	0	0	0	0	0	0	0	0	372,169	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(112,189)	232,995	0	0	0	0	0	0	0	0	0	120,806	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(115,836)	248,305	0	0	0	0	0	0	0	0	0	132,469	29

Summary B

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	Suburban 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 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.

☒ 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		\$ 5,747	\$ 5,747	1
2	V	5	Utilities		Ascension Health		5,225	5,225	2
3	V	6	Maintenance		Ascension Health		4,338	4,338	3
4	V	17	Administration	1,807,693	Ascension Health			(1,807,693)	4
5	V	20	Dues and Fees		Ascension Health		1,065	1,065	5
6	V	21	Clerical and General Office		Ascension Health		1,577,348	1,577,348	6
7	V	22	Benefits	737,061	Ascension Health		827,167	90,106	7
8	V	26	Insurance		Ascension Health		372,169	372,169	8
9	V	30	Depreciation		Ascension Health		38,607	38,607	9
10	V	32	Interest	157	Ascension Health		157		10
11	V	39	Pharmacy	1,406,232	Suburban Pharmacy		1,406,232		11
12	V								12
13	V								13
14	Total			\$ 3,951,143			\$ 4,238,055	\$ * 286,912	14

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

Facility Name & ID Number

ASCENSION VILLA FRANCISCAN

0042861

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
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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

Facility Name & ID Number ASCENSION VILLA FRANCISCAN

0042861

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 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	\$ 5,747	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	5,225	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	4,338	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	1,065	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	1,577,348	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	827,167	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	372,169	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	38,607	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	157	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		\$ 2,831,823	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	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.)

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.

\$	1
----	---

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$	2
----	---

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

\$	0	3
----	---	---

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

\$	4
----	---

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466
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(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.

[illegible]

TOTAL REFUND	\$	For	Tax Year.	(Attach a copy of the real estate tax appeal board's decision.)
--------------	----	-----	-----------	---

\$	6
----	---

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

\$	0	7
----	---	---

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

	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

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 VILLA FRANCISCAN COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0042861

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)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
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: 70,000

B. General Construction Type: Exterior Brick Frame Number of Stories 2

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	1,362,748	1990	\$ 285,994	1
2					2
3	TOTALS	1,362,748		\$ 285,994	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	154		1990	1990	\$ 6,475,673	\$ 78,807	30	\$ 215,856	\$ 137,049	\$ 6,216,058	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1992		29,187	0	20	0		29,187	9
10	VARIOUS		1993		6,242	0	20	0		6,242	10
11	VARIOUS		1994		21,786	0	20	0		21,786	11
12	VARIOUS		1995		79,452	1,706	17	4,674	2,968	76,125	12
13	VARIOUS		1996		41,526	0	10	0		41,526	13
14	VARIOUS		1997		17,775	0	10	0		17,775	14
15	VARIOUS		1998		9,029	0	5	0		9,029	15
16	VARIOUS		1999		4,936	0	7	0		4,936	16
17	VARIOUS		2000		53,879	0	6	0		53,879	17
18	VARIOUS		2001		8,708	0	5	0		8,708	18
19	VARIOUS		2002		3,150	0	10	0		3,150	19
20	VARIOUS		2003		23,864	0	11	0		23,864	20
21	VARIOUS		2004		136,435	0	11	0		136,435	21
22	VARIOUS		2005		45,815	0	11	0		45,815	22
23	VARIOUS		2006		596,144	16,742	13	45,857	29,115	375,634	23
24	VARIOUS		2007		98,492	2,766	13	7,576	4,810	87,709	24
25	VARIOUS		2008		11,614	326	13	893	567	10,529	25
26	VARIOUS		2009		100,683	2,450	15	6,712	4,262	85,910	26
27	VARIOUS		2010		180,957	6,006	11	16,451	10,445	163,608	27
28	VARIOUS		2011		119,924	3,649	12	9,994	6,345	100,210	28
29	VARIOUS		2012		85,350	1,558	20	4,268	2,710	34,342	29
30	ARCHITECT SERVICES CONVERT SEM		2014		278,934	2,546	40	6,973	4,427	41,839	30
31	BOILER		2014		9,600	234	15	640	406	3,840	31
32	CONSTRUCTION CONVERT SEMI PRIV		2014		2,829,183	25,823	40	70,730	44,907	424,378	32
33	IDPH PLAN REVIEW CONVERT SEMI		2014		9,600	88	40	240	152	1,440	33
34	RECEPTION CASEWORK CABINET BUI		2014		16,290	396	15	1,086	690	6,595	34
35	SITE SURVEY CONVERT SEMI PRIVA		2014		950	9	40	24	15	143	35
36	SUBSURFACE GEOTECHNICAL ENGINE		2014		11,540	106	40	289	183	1,732	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 VILLA FRANCISCAN

0042861

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	DOOR RESTRICTOR FOR ELEVATOR	2015	\$ 6,032	\$ 110	20	\$ 302	\$ 192	\$ 1,634	37
38	GENERATOR	2015	3,481	51	25	139	88	707	38
39	SOLID STATE STARTER FOR ELEVAT	2015	7,813	143	20	391	248	2,117	39
40	WATER HEATER	2015	5,928	216	10	593	377	3,014	40
41	COMMODES	2015	1,206	44	10	121	77	709	41
42									42
43	CONSTRUCTN CNVRT SEMI TO PVT - Flooring, Walls, Showe	2014	75,361	1,834	15	5,024	3,190	20,096	43
44	ROOF REPLACEMENT	2015	98,236	1,793	20	4,912	3,119	22,104	44
45	New wall/corner protection - Cambridge Unit	2016	14,921	272	20	746	474	3,357	45
46	INTERIOR PAINTING - Domiano & Cambridge Units	2016	6,000	219	10	600	381	2,700	46
47	New wall and corner protection - Domiano Unit	2016	7,290	133	20	365	232	1,641	47
48	Carpet and tile replacement - Domiano Units & Bathrooms	2016	12,986	474	10	1,299	825	4,979	48
49	PROVIDE/INSTALL TEKNOFLOR - Domiano Unit	2016	11,193	204	20	560	356	2,519	49
50	DIELECTRIC UNION REPLACEMENT - Domiano Unit Bathro	2015	28,000	511	20	1,400	889	6,300	50
51	SIDEWALK / PARKING LOT REPAIR,	2016	10,314	188	20	516	328	2,321	51
52									52
53	CHILLER	2017	164,712	3,007	20	8,236	5,229	24,021	53
54									54
55	Install New Sidewalks and Repl	2018	5,250	96	20	263	167	263	55
56	Water Storm Sanitory	2018	46,000	840	20	2,300	1,460	2,300	56
57									57
58	Water Softener	2019	26,500	645	15	1,767	1,122	3,534	58
59	PIPE INSULATION	2019	35,000	852	15	2,333	1,481	4,666	59
60	PIPE INSULATION	2019	64,200	1,563	15	4,280	2,717	8,560	60
61	Widow Replacement	2019	112,908	4,122	10	11,291	7,169	22,582	61
62				0		0		0	62
63	Vinyl Flooring throughout community	2020	34,488	1,259	10	3,449	2,190	3,449	63
64	PO Request Tuck Pointing	2020	31,875	582	20	1,594	1,012	1,594	64
65	Window Replacement	2020	112,908	4,122	10	11,291	7,169	11,291	65
66	Elevator Controllers-OTIS	2020	45,706	834	20	2,285	1,451	2,285	66
67	7/1/19 Capital Rate Adjusmtents	2020	(59,151)						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,215,876	\$ 167,326		\$ 458,320	\$ 290,994	\$ 8,191,167	70

**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	\$ 1,353,617	\$ 37,797	\$ 103,521	\$ 65,724	Various	\$ 831,341	71
72	Current Year Purchases	251,901	10,679	29,250	18,571	Various	29,250	72
73	Fully Depreciated Assets	1,088,912			0		1,088,912	73
74	Home Office Allocation		38,607	38,607	0			74
75	TOTALS	\$ 2,694,430	\$ 87,083	\$ 171,378	\$ 84,295		\$ 1,949,503	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		\$
77							0		
78							0		
79							0		
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0

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)			\$	15,196,300
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	254,409
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	629,698
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	375,289
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	10,140,670

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$ 117,758 Description: Admin 527; Dietary 1,879; Environmental 1,807; Therapy 3,000; Nursing 110,545.
(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, 3	hrs	\$		\$ 739,328	\$		\$ 739,328	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			88,910			88,910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			581,715	3,491		585,206	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				1,424,739		1,424,739	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			\$		\$ 1,409,953	\$ 1,428,230		\$ 2,838,183	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	\$ 22,882	\$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,240,512	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	36,617	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	14,869	93,121,433	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,314,880	\$ 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	736,000	84,567,210	13
14	Buildings, at Historical Cost	2,775,945	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	842,861	111,043,559	16
17	Accumulated Depreciation (book methods)	(419,908)	(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)	\$ 3,934,898	\$ 636,045,090	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,249,778	\$ 783,464,338	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 271,916	\$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	212,663	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	170,610	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>	95,671	4,954,006	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 750,860	\$ 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)	\$ 750,860	\$ 417,821,300	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,498,918	\$ 365,643,038	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,249,778	\$ 783,464,338	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,818,263	1
2	Restatements (describe):		2
3	Adj to Reconcile	820,740	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,639,003	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,140,085)	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)	\$ (1,140,085)	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)	\$ 4,498,918	24

* This must agree with page 17, line 47.

Facility Name & ID Number ASCENSION VILLA FRANCISCAN

0042861

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	\$ 10,260,356	1
2	Discounts and Allowances for all Levels	(3,607,276)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,653,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,375,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,375,060	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	880,005	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,267	13
14	Non-Patient Meals	1,850	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,328,410	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)	\$ 3,212,532	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	26,881	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,931	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	145,061	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 145,061	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,412,664	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,849,063	31
32	Health Care	6,757,993	32
33	General Administration	3,788,842	33
	B. Capital Expense		
34	Ownership	385,312	34
	C. Ancillary Expense		
35	Special Cost Centers	1,539,618	35
36	Provider Participation Fee	231,921	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,552,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,140,085)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,140,085)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,226,804	44
45	Private Pay - Net Inpatient Revenue	735,082	45
46	Medicare - Net Inpatient Revenue	2,585,041	46
47	Other-(specify) <u>Insurance</u>	1,106,153	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,653,080	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	464	532	\$ 28,531	\$ 53.63	1
2	Assistant Director of Nursing	319	378	13,242	35.03	2
3	Registered Nurses	55,459	63,098	2,570,706	40.74	3
4	Licensed Practical Nurses	6,060	6,983	217,443	31.14	4
5	CNAs & Orderlies	52,222	60,363	1,019,902	16.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,571	1,907	35,920	18.84	9
10	Activity Assistants	5,550	6,189	85,077	13.75	10
11	Social Service Workers	4,883	5,566	128,673	23.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,280	8,061	151,656	18.81	17
18	Housekeepers	12,208	13,573	174,146	12.83	18
19	Laundry	1,576	1,872	23,471	12.54	19
20	Administrator	1,936	2,160	127,085	58.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,975	4,277	90,974	21.27	23
24	Clerical	11,842	12,846	203,069	15.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	208	208	20,000	96.15	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,757	1,937	32,582	16.82	31
32	Other Health C: Admissions	7,658	8,500	202,469	23.82	32
33	Other(specify) Pastoral	1,941	2,117	53,768	25.40	33
34	TOTAL (lines 1 - 33)	176,909	200,567	\$ 5,178,714 *	\$ 25.82	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	Monthly	22,725	9, 3	36
37	Medical Records Consultant	35	2,593	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	332	21,675	10, 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,076	11, 3	44
45	Social Service Consultant	65	4,502	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 53,571		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,508	\$ 168,764	10	50
51	Licensed Practical Nurses	2,232	104,987	10	51
52	Certified Nurse Assistants/Aides	14,406	359,459	10	52
53	TOTAL (lines 50 - 52)	19,146	\$ 633,210		53

Facility Name & ID Number		ASCENSION VILLA FRANCISCAN		STATE OF ILLINOIS		# 0042861		Report Period Beginning:		7/1/19		Page 21		Ending:		6/30/20	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount							
Elliot Triplett		Administrator		\$ 127,085	Workers' Compensation Insurance		\$	IDPH License Fee		\$							
					Unemployment Compensation Insurance			Advertising: Employee Recruitment									
					FICA Taxes		396,276	Health Care Worker Background Check									
					Employee Health Insurance		571,685	(Indicate # of checks performed 64)									
					Employee Meals			Patient Background Checks		467							
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		39,854							
					Dental		15,078	Home Office Allocation		1,065							
					Life Insurance		5,377										
					Disability		83,009										
					Pension		94,099										
					Tuition Reimbursement		2,394	Less: Public Relations Expense		()							
					Other Benefits		78,935	Non-allowable advertising		(2,074)							
					Home Office Allocation & Marketing Offset		85,320	Yellow page advertising		()							
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 127,085	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,332,173	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,845							
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**								
Description				Amount	Description		Line #	Amount	Description		Amount						
Corp Office Management Fee				\$ 1,807,693	N/A			\$	Out-of-State Travel		\$						
									In-State Travel		1,508						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 1,807,693					Seminar Expense								
C. Professional Services																	
Vendor/Payee		Type		Amount													
Universal Background Screening, Inc		HR Services		\$ 1,842													
Non-Allowable Legal Fees		Non-Allowable Legal Fees		8,056													
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 9,898	TOTAL			\$	Entertainment Expense		()						
									(agree to Sch. V, line 24, col. 8)								
									TOTAL		\$ 1,508						
* Attach copy of IMRF notifications																	
**See instructions.																	

Facility Name & ID Number ASCENSION VILLA FRANCISCAN	STATE OF ILLINOIS # 0042861	Report Period Beginning: 7/1/19	Ending: 6/30/20
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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 - \$16,264

(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. \$ 68,410 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. \$ 231,921
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,850

(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