		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0054072

Facility Name: ASCENSION NAZARETHVILLE PLC

Address: 300 NORTH RIVER ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: (847) 297-5900 **Fax #** (847) 297-0504

HFS ID Number:

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

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501c3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact
Name: MATT LANKFORD **Telephone Number:** (317) 207-0368
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 7/1/24 to 6/30/25 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) Lisa Orzada
(Title) DIRECTOR OF BUSINESS OPERATIONS

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) ERIC J. NEIDIG, PARTNER
(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
2200 Churchill Rd.
Springfield, IL 62702-3406 **Phone # (217) 782-1630**

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NONE

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,475	5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	Level of Care	1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	6,164	9,274	1,751	17	4,775	1,322	435	23,738	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,164	9,274	1,751	17	4,775	1,322	435	23,738	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 78.36%

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 certified beds.
number of certified beds 34

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: 6/30/25 Fiscal Year: 6/30/25

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary		43,875	634,258	678,133		678,133	0	678,133			1
2	Food Purchase		212,053		212,053		212,053	(47,919)	164,134			2
3	Housekeeping	129,524	24,966	572	155,062		155,062	5,569	160,631			3
4	Laundry	66,289	0	84,639	150,928	0	150,928	0	150,928			4
5	Heat and Other Utilities			231,570	231,570		231,570	10	231,580			5
6	Maintenance	147,954	12,608	163,558	324,120		324,120	438	324,558			6
7	Other (specify):* PASTORAL	85,538	0	7,005	92,542		92,542	0	92,542			7
8	**TOTAL General Services**	429,305	293,502	1,121,602	1,844,409	0	1,844,409	(41,902)	1,802,507			8
	B. Health Care and Programs											
9	Medical Director	0	0	7,500	7,500		7,500	0	7,500			9
10	Nursing and Medical Records	3,362,564	108,034	179,491	3,650,089		3,650,089	(15)	3,650,074			10
10a	Therapy	0	0	370,933	370,933		370,933	0	370,933			10a
11	Activities	149,431	3,203	3,272	155,906		155,906	0	155,906			11
12	Social Services	63,299	0	5,184	68,483		68,483	0	68,483			12
13	CNA Training	0	0	0	0		0	0	0			13
14	Program Transportation	0	0	637	637		637	0	637			14
15	Other (specify):*	0	0	0	0		0	0	0			15
16	**TOTAL Health Care and Programs**	3,575,294	111,237	567,017	4,253,548	0	4,253,548	(15)	4,253,533			16
	C. General Administration											
17	Administrative	165,604	0	716,875	882,478		882,478	(716,875)	165,604			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			5,797	5,797		5,797	0	5,797			19
20	Dues, Fees, Subscriptions & Promotions			22,693	22,693		22,693	(499)	22,194			20
21	Clerical & General Office Expenses	207,689	16,524	24,999	249,211		249,211	1,195,741	1,444,952			21
22	Employee Benefits & Payroll Taxes			1,003,811	1,003,811		1,003,811	39,568	1,043,379			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			1,663	1,663		1,663	0	1,663			24
25	Other Admin. Staff Transportation			0	0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			360,362	360,362		360,362	8,942	369,304			26
27	Other (specify):*			0	0		0	0	0			27
28	**TOTAL General Administration**	373,292	16,524	2,136,199	2,526,015	0	2,526,015	526,877	3,052,893			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,377,891	421,263	3,824,818	8,623,972	0	8,623,972	484,960	9,108,933			29

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

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC #0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			352,525	352,525		352,525	131,905	484,430			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			84,000	84,000		84,000	0	84,000			34
35	Rent-Equipment & Vehicles			40,672	40,672		40,672	0	40,672			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			477,197	477,197	0	477,197	131,905	609,102			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			90,800	90,800		90,800	0	90,800			39
40	Barber and Beauty Shops			15,998	15,998		15,998	0	15,998			40
41	Coffee and Gift Shops			0	0		0	0	0			41
42	Provider Participation Fee			480,212	480,212		480,212	0	480,212			42
43	Other (specify):* LAB & RADIOLOGY			13,893	13,893		13,893	0	13,893			43
44	**TOTAL Special Cost Centers**	0	0	600,903	600,903	0	600,903	0	600,903			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,377,891	421,263	4,902,919	9,702,073	0	9,702,073	616,865	10,318,938			45

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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	(47,919)	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	128,127	30		9
10	Interest and Other Investment Income				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	(2,359)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,305)	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	(4,992)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 71,552		$ 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)	545,313	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 545,313		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 616,865		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						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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASCENSION NAZARETHVILLE PLC

ID# 0054072

Report Period Beginning: 7/1/24

Ending: 6/30/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (420)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Vendor Rebates	(4,557)	21	3
4	Medical Record Fees	(15)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,992)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(47,919)	0	0	0	0	0	0	0	0	0	0	(47,919)	2
3	Housekeeping	0	5,569	0	0	0	0	0	0	0	0	0	5,569	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	10	0	0	0	0	0	0	0	0	0	10	5
6	Maintenance	0	438	0	0	0	0	0	0	0	0	0	438	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(47,919)	6,017	0	0	0	0	0	0	0	0	0	(41,902)	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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	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 Program**	(15)	0	0	0	0	0	0	0	0	0	0	(15)	16
	C. General Administration													
17	Administrative	0	(716,875)	0	0	0	0	0	0	0	0	0	(716,875)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,725)	1,226	0	0	0	0	0	0	0	0	0	(499)	20
21	Clerical & General Office Expenses	(6,916)	1,202,657	0	0	0	0	0	0	0	0	0	1,195,741	21
22	Employee Benefits & Payroll Taxes	0	39,568	0	0	0	0	0	0	0	0	0	39,568	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	8,942	0	0	0	0	0	0	0	0	0	8,942	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,641)	535,518	0	0	0	0	0	0	0	0	0	526,877	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,575)	541,535	0	0	0	0	0	0	0	0	0	484,960	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	128,127	3,778	0	0	0	0	0	0	0	0	0	131,905	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	128,127	3,778	0	0	0	0	0	0	0	0	0	131,905	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	71,552	545,313	0	0	0	0	0	0	0	0	0	616,865	45

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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
Lisa Musgrave	BOD	Ascension Living	Various	Ascension Health	Various	Healthcare System
Rob Binek	BOD	Ascension St. Joseph Village	Freeport			
Ryan Breedlove	BOD	Ascension St. Anne Place	Rockford			
Erin Shadbolt	BOD	Ascension Resurrection Life	Chicago			
Bob Smoot	BOD					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Ascension Health		$ 5,569	$ 5,569	1
2	V	5	Utilities		Ascension Health		10	10	2
3	V	6	Maintenance		Ascension Health		438	438	3
4	V	17	Administration	716,875	Ascension Health			(716,875)	4
5	V	20	Dues & Fees		Ascension Health		1,226	1,226	5
6	V	21	Clerical & General Office		Ascension Health		1,202,657	1,202,657	6
7	V	22	Benefits		Ascension Health		39,568	39,568	7
8	V	26	Insurance		Ascension Health		8,942	8,942	8
9	V	30	Depreciation		Ascension Health		3,778	3,778	9
10	V	22	Benefits	567,984	Ascension Health		567,984		10
11	V	26	Insurance	340,890	Ascension Health		340,890		11
12	V	39	Pharmacy	85,930	Ascension Health		85,930		12
13	V								13
14	Total			$ 1,711,679			$ 2,256,992	$ * 545,313	14

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

STATE OF ILLINOIS **Ownership Listing-1**

ASCENSION NAZARETHVILLE PLC

ID# **0054072**

Report Period Beginning: **7/1/24**

Ending: **6/30/25**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Lisa		Musgrave	St Louis	MO	0.00000	0.00000	0.00000	1
2	Rob		Binek	St Louis	MO	0.00000	0.00000	0.00000	2
3	Ryan		Breedlove	St Louis	MO	0.00000	0.00000	0.00000	3
4	Erin		Shadbolt	St Louis	MO	0.00000	0.00000	0.00000	4
5	Bob		Smoot	St Louis	MO	0.00000	0.00000	0.00000	5
6									6
7									7
8									8
9									9
10									10
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12									12
13									13
14									14
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16									16
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75									75

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Ascension Health
Street Address: 4600 Edmundson
City / State / Zip Code: St. Louis, MO 63134
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	10	$ 34,611	$	Various	$ 5,569	1
2	5	Utilities	Direct Cost	Various	10	63		Various	10	2
3	6	Maintenance	Direct Cost	Various	10	2,720		Various	438	3
4	20	Dues & Fees	Direct Cost	Various	10	7,621		Various	1,226	4
5	21	Clerical & General Office	Direct Cost	Various	10	7,474,150	1,110,979	Various	1,202,657	5
6	22	Benefits	Direct Cost	Various	10	245,903		Various	39,568	6
7	26	Insurance	Direct Cost	Various	10	55,572		Various	8,942	7
8	30	Depreciation	Direct Cost	Various	10	23,480		Various	3,778	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,844,120	$ 1,110,979		$ 1,262,188	25

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 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 NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	0	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	0	7

Assessed Value from Real Estate Tax Bill: **2024** ____ **8**

Real Estate Tax Bill for Calendar Year:

2020	____	**9**
2021	____	**10**
2022	____	**11**
2023	____	**12**
2024	____	**13**

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	**14**
15	PLUS APPEAL COST FROM LINE 5	$	**15**
16	LESS REFUND FROM LINE 6	$	**16**
17	AMOUNT TO USE FOR RATE CALCULATION	$	**17**

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASCENSION NAZARETHVILLE PLC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054072

CONTACT PERSON REGARDING THIS REPORT Matt Lankford

TELEPHONE (317) 207-0368 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 83,762 **B. General Construction Type:** **Exterior** Brick **Frame** **Number of Stories** 1

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

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

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

NONE

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? YES

H. Are you presently operating under a sale and leaseback arrangement? NO

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? NO

J. 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.

K. **Does this cost report reflect any organization or pre-operating costs which are being amortized?** [ ] **YES** [X] **NO**

If so, please complete the following:

1. Total Amount Incurred: **2. Number of Years Over Which it is Being Amortized:**

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CHAPEL RENOVATIONS			2014	36,000	880	30	1,200	320	18,068	9
10	L M TO EXTEND 20 AMP 3 PHASE 2			2014	2,738	81	25	110	29	1,204	10
11	L M TO INSTALL TWO DOOR RESTRI			2014	2,350	87	20	118	31	1,290	11
12	NEW ARMSTRONG VINYL SHEET IN 7			2014	25,550	1,249	15	1,703	454	18,618	12
13	NEW KARNDEAN DESIGN FLOORING			2014	64,426	1,890	25	2,577	687	39,229	13
14	REPLACEMENT OF DOORS TO PATIO			2014	2,100	103	15	140	37	1,536	14
15	REPLACEMENT OF FLOORING IN CHA			2014	21,579	0	10	0		21,579	15
16	SOFFIT FASCIA REPLACEMENT GUT			2014	20,755	761	20	1,038	277	11,365	16
17	SUMP PUMP SYSTEM			2015	6,389	390	10	532	142	6,389	17
18	Naz Room Expansion Project			2015	14,400	264	40	360	96	4,500	18
19	BOILER BURNER & CONTROLS UPGRD			2015	55,935	2,051	20	2,797	746	27,270	19
20	ELEVATOR UPGRADES-HEAT DETECTR			2015	26,627	976	20	1,331	355	12,978	20
21	FAN COILS AND BACK PLATES			2015	50,669	1,858	20	2,533	675	24,698	21
22	FIRE DAMPER DUCTWORK MAIN BOIL			2015	18,300	671	20	915	244	8,921	22
23	FLOORING FOR ADM OFFICE			2015	3,885	285	10	389	104	3,791	23
24	INSTALL FIRE DAMPERS BOILR RM			2015	5,600	205	20	280	75	2,730	24
25	INSTALL LIGHTING FIXTURES			2015	42,645	1,564	20	2,132	568	20,788	25
26	L & M INSTALL VFDS			2015	300,810	11,032	20	15,041	4,009	146,648	26
27	L M TO INSTALL TWO DOOR RESTRI			2015	2,350	43	40	59	16	877	27
28	L M TO INSTALL TWO WALL PACK L			2015	14,871	546	20	744	198	8,137	28
29	MATERIAL LED EXIT RETROFIT			2015	66,902	2,453	20	3,345	892	32,614	29
30	MATERIAL, CONTROLLERS VFD PROJ			2015	152,700	5,600	20	7,635	2,035	74,441	30
31	MATL CONTROLLERS VFD PROJECT			2015	14,400	528	20	720	192	7,020	31
32	NEWSPRINKLER HEADS 2+3 FL			2015	18,300	671	20	915	244	8,921	32
33	NEW THERMOSTATS			2015	17,640	647	20	882	235	8,600	33
34	NEW ROOF			2015	177,980	8,702	15	11,865	3,163	117,662	34
35	NEW SPRIKLER HEADS			2015	39,850	1,462	20	1,993	531	19,430	35
36	AUTOMATIC DOOR OPENER			2015	4,697	172	20	235	63	2,291	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 NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	: Door Levers for Resident R	2016	$ 19,930	$ 1,462	10	$ 1,993	$ 531	$ 18,269	37
38	: Sidewalk Replacement	2016	5,000	244	15	333	89	3,164	38
39	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,667	61	20	83	22	720	39
40	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	8,275	304	20	414	110	3,553	40
41	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,143	42	20	57	15	542	41
42	LIFT GATE - Front Entrance Common Area	2016	53	2	20	3	1	27	42
43	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	3,540	130	20	177	47	1,608	43
44	Electric Sliding Doors - Front Entrance	2016	13,266	486	20	663	177	6,244	44
45									45
46	NEW DYER VENTING	2017	7,100	260	20	355	95	2,692	46
47	NEW PARKING LOT	2017	33,910	1,658	15	2,261	603	17,340	47
48	NEW WATER PIPING SYSTEM	2017	799,399	14,658	40	19,985	5,327	166,917	48
49									49
50	EM Power For Command Center	2017	10,160	373	20	508	135	3,810	50
51									51
52	Boiler Combustion Motor	2018	4,695	172	20	235	63	1,410	52
53	Fire Door Compliance	2018	9,025	442	15	602	160	3,612	53
54	Parking Lot Repairs	2018	33,000	1,614	15	2,200	586	13,200	54
55									55
56	New Fire Alarm Panel	2019	39,150	1,436	20	1,958	522	13,706	56
57	Elevator Door Safety Edges	2019	7,412	543	10	741	198	5,187	57
58	BUNDLED CARPETING OFFICES	2019	4,335	0	5	0		4,335	58
59				0		0		0	59
60	Building Tuck Pointing	2020	15,250	1,118	10	1,525	407	9,150	60
61	Bundled Generator EM Connection	2020	53,156	1	5	1		53,156	61
62	7/1/19 Capital Rate Adjustments	2020	(1,028,836)						62
63									63
64	Mixing valves	2021	52,060	3,818	10	5,206	1,388	26,030	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,303,138	$ 73,995		$ 100,889	$ 26,894	$ 1,006,267	70

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,303,138	$ 73,995		$ 100,889	$ 26,894	$ 1,006,267	1
2	WanderGuard	2022	78,578	3,842	15	5,239	1,396	20,954	2
3	Interior Signage	2022	20,345	2,984	5	4,069	1,085	16,276	3
4	Supply and Return Valves	2022	9,870	483	15	658	175	2,632	4
5	Exterior Signage	2022	24,102	1,768	10	2,410	642	9,641	5
6	Network Project IT - Remove existing wired and wireless	2022	1,186,866	174,097	5	237,373	63,276	949,493	6
7	network equipment throughout the facility. Install new wired and								7
8	wireless network throughout the facility, including								8
9	hardware and cables.								9
10	Telecom Project IT - Remove existing telecommunications	2022	56,913	8,348	5	11,383	3,035	45,530	10
11	equipment throughout the facility. Install								11
12	new telecommunications throughout the facility.								12
13	Kitchen 6 Burner Stove	2022	12,067	443	20	603	160	2,413	13
14	Double Decl Convection Oven	2022	8,955	328	20	448	120	1,791	14
15									15
16	Telecom Project IT Phase 2 - Part 2 of 2022 Telecom Project	2023	12,452	1,827	5	2,490	663	7,471	16
17									17
18	Main Data Room AC Unit FY24	2024	13,946	682	15	930	248	1,859	18
19	Walk In Cooler Repair	2024	16,793	821	15	1,120	298	2,239	19
20	Chicago Network Project - Part 2 of 2022 Network Project	2024	61,571	9,032	5	12,314	3,283	24,628	20
21									21
22	Center Garden Patio	2025	5,200	254	15	347	92	347	22
23	NNH Parking Lot	2025	8,400	770	8	1,050	280	1,050	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,819,196	$ 279,674		$ 381,322	$ 101,648	$ 2,092,591	34

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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	$ 801,456	$ 46,377	$ 63,232	$ 16,855	Various	$ 610,372	71
72	Current Year Purchases	117,262	26,475	36,097	9,622	Various	36,098	72
73	Fully Depreciated Assets	561,246			0		561,246	73
74	Home Office Allocation		3,778	3,778	0			74
75	TOTALS	$ 1,479,964	$ 76,630	$ 103,107	$ 26,477		$ 1,207,716	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	Patient Transportation	2020 Ford E-450	2020	$ 66,571	$ 0	$ 0	$ 0	5	$ 66,571	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 66,571	$ 0	$ 0	$ 0		$ 66,571	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,365,731	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 356,304	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 484,429	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 128,125	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,366,878	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SISTERS OF THE HOLY FAMILY OF NAZARETH
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 [X] 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:	Unknown	83	1/1/2012	$ 84,000	3	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		83		$ 84,000 **			7

10. Effective dates of current rental agreement:
Beginning 1/1/2023
Ending 12/31/2025

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2025	$ 84,000
13.	/2027	$
14.	/2028	$

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 . 0

9. Option to Buy: [ ] YES [X] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 40,672 Description: Nursing $40,672
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$		$ 130,173	$		$ 130,173	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			101,257			101,257	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			139,502			139,502	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				90,800		90,800	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			$		$ 370,932	$ 90,800		$ 461,732	14

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/25 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,579	$ 5,220,729	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	792,672	33,133,238	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,276	1,463,098	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	16,536	43,660,694	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 880,063	$ 83,477,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		125,275,442	12
13	Land	70,702	68,727,908	13
14	Buildings, at Historical Cost	222,134	318,632,245	14
15	Leasehold Improvements, at Historical Cost		1,044,383	15
16	Equipment, at Historical Cost	2,023,043	80,184,781	16
17	Accumulated Depreciation (book methods)	(1,457,617)	(231,197,995)	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): Assets held for sale & Other Misc		11,676,567	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 858,262	$ 374,343,331	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,738,325	$ 457,821,090	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 150,382	$ 83,079,972	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	207,133	6,998,416	28
29	Short-Term Notes Payable		100,866,380	29
30	Accrued Salaries Payable	279,388	10,756,086	30
31	Accrued Taxes Payable (excluding real estate taxes)		269,492	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,081,623	32
33	Accrued Interest Payable			33
34	Deferred Compensation		104,417	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties	29,578	3,469,121	36
37	IC PAYABLES	6,583	34,345,450	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 673,064	$ 240,970,957	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		114,059,271	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	$ 114,059,271	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 673,064	$ 355,030,228	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,065,261	$ 102,790,862	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,738,325	$ 457,821,090	48

***(See instructions.)**

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,193,598	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,193,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,336,544)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	12,171	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,324,373)	17
	B. Transfers (Itemize):		
18	IC TRANSFER	2,196,036	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,196,036	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,065,261	24 *

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

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,191,280	1
2	Discounts and Allowances for all Levels	(3,324,437)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,866,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	372,342	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 372,342	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,676	13
14	Non-Patient Meals	47,919	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	24,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,704	19
20	Radiology and X-Ray	5,820	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 108,816	23
	D. Non-Operating Revenue		
24	Contributions	16,433	24
25	Interest and Other Investment Income***	531	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,964	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Revenue	564	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 564	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,365,529	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,844,409	31
32	Health Care	4,253,548	32
33	General Administration	2,526,015	33
	B. Capital Expense		
34	Ownership	477,198	34
	C. Ancillary Expense		
35	Special Cost Centers	120,691	35
36	Provider Participation Fee	480,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,702,073	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,336,544)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,336,544)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,868,938.77	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,748,462.26	45
46	MMAI-Medicaid is the Primary Payer	318,066.81	46
47	MMAI-Medicare is the Primary Payer	6,148.12	47
48	Private Pay	1,572,301.68	48
49	Medicare Part A	803,944.62	49
50	Other-(specify) Insurance	548,979.97	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,866,842	56

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,395	1,736	$ 128,144	$ 73.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,329	30,175	1,546,190	51.24	3
4	Licensed Practical Nurses	3,067	3,406	128,973	37.87	4
5	CNAs & Orderlies	51,223	56,352	1,559,256	27.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	2,062	46,175	22.39	9
10	Activity Assistants	5,428	5,901	103,256	17.50	10
11	Social Service Workers	1,884	2,066	63,299	30.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,435	4,192	147,954	35.29	17
18	Housekeepers	6,865	7,225	129,524	17.93	18
19	Laundry	3,338	3,755	66,289	17.65	19
20	Administrator	1,688	2,053	165,604	80.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,566	2,719	81,424	29.95	23
24	Clerical	3,893	4,232	83,465	19.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca ADMISSIONS	1,173	1,463	42,800	29.25	32
33	Other(specify) PASTORAL	2,223	2,717	85,538	31.48	33
34	TOTAL (lines 1 - 33)	117,355	130,054	$ 4,377,891 *	$ 33.66	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	7,500	9, 3	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	117	5,184	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	$ 12,684		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	874	$ 69,390	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,600	93,143	10, 3	52
53	TOTAL (lines 50 - 52)	3,474	$ 162,533		53

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Lynn Brown	Administrator		$ 165,604
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,604

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 716,875
TOTAL (agree to Schedule V, line 17, col. 3)	$ 716,875
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening	HR	$ 5,559
Language Line Services	Interpreter	23
LW Consulting	Healthcare & Compliance Cons	215
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,797

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,705
Unemployment Compensation Insurance	19,418
FICA Taxes	324,697
Employee Health Insurance	473,751
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	(5,802)
Life Insurance	1,769
Disability	18,209
Pension	97,375
Other	48,689
Home Office Allocation & Other Offsets	39,568
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,043,379

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 33)	
Patient Background Checks 126	
Association Dues (total from pg 22, #4)	6,417
Dues & Subscriptions	16,276
Home Office Allocation	1,226
Less: Public Relations Expense	( )
PAC and Lobbying payments	(420)
All non-allowable advertising	(1,305)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,194

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	904
Seminar Expense	759
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,663

**See instructions.

Facility Name & ID Number ASCENSION NAZARETHVILLE PLC # 0054072 Report Period Beginning: 7/1/24 Ending: 6/30/25

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name	Amount
LEADING AGE	5,997
	5,997 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

LEADING AGE	420
0	
0 0	
	420 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE	6,417
0	0
0 0	0
	0
	6,417 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V. $ 48,380 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ 480,212
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) Have costs for all supplies and services which are of the type that can be billed t
the Department, in addition to the daily rate, been properly classifie
in the Ancillary Section of Schedule V' YES

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ NONE Has any meal income been offset agains
related costs? YES Indicate the amount. $ 47,919

(12) 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 othe
times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

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

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

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