

		FOR BHF USE						

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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: <u>0044354</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>ASCENSION RESURRECTION LIFE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/24</u> to <u>6/30/25</u> 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.																																																	
Address: <u>7370 W TALCOTT AVE</u> <u>CHICAGO</u> <u>60631</u> Number City Zip Code																																																			
County: <u>COOK</u>																																																			
Telephone Number: <u>(773) 594-7400</u> Fax # <u>(773) 594-7402</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>03-01-00</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Lisa Orzada</u> (Title) <u>DIRECTOR OF BUSINESS OPERATIONS</u>																																																	
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td>IRS Exemption Code <u>501c3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐	IRS Exemption Code <u>501c3</u>	☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	☐	_____			☐	Limited Liability Co.	☐	_____			☐	Trust	☐	_____			☐	Other	☐	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>ERIC J. NEIDIG</u> <u>PARTNER</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	
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		☐	Trust	☐	_____																																														
		☐	Other	☐	_____																																														
In the event there are further questions about this report, please contact Name: <u>MATT LANKFORD</u> Telephone Number: <u>(317) 207-0368</u> Email Address: _____																																																			
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																																																	

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberASCENSION RESURRECTION LIFE# 0044354Report Period Beginning: 7/1/24Ending: 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	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	122	122	44,530
2	Skilled Pediatric (SNF/PED)		
3	35	35	12,775
4	Intermediate/DD		
5	5	5	1,825
6	Sheltered Care (SC)		
7	ICF/DD 16 or Less		
7	162	162	59,130

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9	
Level of Care	Patient Days by Level of Care and Primary Source of Payment								
	Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
			Medicaid Primary	Medicare Primary					
8	SNF	3,995	11,233	836	163	9,887	14,232	6,349	46,695
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	3,995	11,233	836	163	9,887	14,232	6,349	46,695

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

78.97%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

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

Date

03/01/00

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

If YES, enter certified beds.

number of certified beds

122

Medicare Intermediary

NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

6/30/25

Fiscal Year:

6/30/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjus-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary		68,600	1,047,438	1,116,038		1,116,038		1,116,038		1
2	Food Purchase		405,451		405,451		405,451	(1,773)	403,678		2
3	Housekeeping	211,248	58,801	666	270,715		270,715	11,253	281,968		3
4	Laundry	67,759	1,522	151,688	220,969		220,969	(64)	220,905		4
5	Heat and Other Utilities			205,396	205,396		205,396	20	205,416		5
6	Maintenance	109,218	7,155	186,876	303,249		303,249	884	304,133		6
7	Other (specify):* PASTORAL	60,620	252	3,718	64,590		64,590		64,590		7
8	TOTAL General Services	448,845	541,780	1,595,782	2,586,407		2,586,407	10,320	2,596,727		8
	B. Health Care and Programs										
9	Medical Director	21,875			21,875		21,875		21,875		9
10	Nursing and Medical Records	6,181,410	253,632	1,805,674	8,240,716		8,240,716	(7,160)	8,233,556		10
10a	Therapy		2,586	1,326,535	1,329,121		1,329,121		1,329,121		10a
11	Activities	136,131	2,364	1,573	140,068		140,068		140,068		11
12	Social Services	153,235		8,905	162,140		162,140		162,140		12
13	CNA Training										13
14	Program Transportation			1,849	1,849		1,849		1,849		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,492,651	258,582	3,144,535	9,895,768		9,895,768	(7,160)	9,888,608		16
	C. General Administration										
17	Administrative	150,883		1,322,149	1,473,032		1,473,032	(1,322,149)	150,883		17
18	Directors Fees										18
19	Professional Services			18,266	18,266		18,266	(1,367)	16,899		19
20	Dues, Fees, Subscriptions & Promotions			44,130	44,130		44,130	(4,381)	39,749		20
21	Clerical & General Office Expenses	359,519	13,691	268,698	641,908		641,908	2,423,997	3,065,905		21
22	Employee Benefits & Payroll Taxes			1,633,994	1,633,994		1,633,994	79,947	1,713,941		22
23	Inservic Training & Education			722	722		722		722		23
24	Travel and Seminar			2,959	2,959		2,959		2,959		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			691,736	691,736		691,736	18,067	709,803		26
27	Other (specify):*										27
28	TOTAL General Administration	510,402	13,691	3,982,654	4,506,748		4,506,748	1,194,114	5,700,862		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,451,898	814,052	8,722,972	16,988,923		16,988,923	1,197,274	18,186,197		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 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
	D. Ownership										
30	Depreciation			489,986	489,986		489,986	186,956	676,941		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			383,667	383,667		383,667	(1,562)	382,105		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			34,145	34,145		34,145		34,145		35
36	Other (specify):*										36
37	TOTAL Ownership			907,798	907,798		907,798	185,394	1,093,191		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			747,594	747,594		747,594		747,594		39
40	Barber and Beauty Shops			19,871	19,871		19,871		19,871		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			716,418	716,418		716,418		716,418		42
43	Other (specify):* LAB AND RADIOLOGY			97,468	97,468		97,468		97,468		43
44	TOTAL Special Cost Centers			1,581,352	1,581,352		1,581,352		1,581,352		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,451,898	814,052	11,212,121	19,478,072		19,478,072	1,382,668	20,860,739		45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,773)	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	(64)	4		8
9	Non-Straightline Depreciation	179,322	30		9
10	Interest and Other Investment Income	(1,562)	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	(5,000)	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	(5,864)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(10,489)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 154,570		\$	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	2	
		Amount	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)	1,228,098	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,228,098		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 1,382,668		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	2	3	4	
		Yes	No	Amount	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

Report Period Beginning: ID# 0044354

Ending: 7/1/24

6/30/25

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (995)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Vendor Rebates	(7,160)	10	4
5	Med Records	(967)	21	5
6				6
7	Non-allowable collections	(1,367)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	(10,489)		49

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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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 Nazarethville Place	Des Plaines			
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.

☒ 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	\$	Ascension Health		\$ 11,253	\$ 11,253	1
2	V	5	Utilities		Ascension Health		20	20	2
3	V	6	Maintenance		Ascension Health		884	884	3
4	V	17	Administration	1,322,149	Ascension Health			(1,322,149)	4
5	V	20	Dues & Fees		Ascension Health		2,478	2,478	5
6	V	21	Clerical & General Office		Ascension Health		2,429,964	2,429,964	6
7	V	22	Benefits		Ascension Health		79,947	79,947	7
8	V	26	Insurance		Ascension Health		18,067	18,067	8
9	V	30	Depreciation		Ascension Health		7,634	7,634	9
10	V	22	Benefits	983,856	Ascension Health		983,856		10
11	V	26	Insurance	691,736	Ascension Health		691,736		11
12	V	39	Pharmacy	401,642	Ascension Health		401,642		12
13	V	32	Interest	383,667			383,667		13
14	Total			\$ 3,783,050			\$ 5,011,148	\$ * 1,228,098	14

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

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.

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.)

YESXNO

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

Name of Related OrganizationAscension Health
Street Address4600 Edmundson
City / State / Zip CodeSt. Louis, MO 63134
Phone Number(816) 596-5608
Fax Number()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Direct Cost	Various	10	\$ 34,611	\$	Various	11,253	1
2	5	Utilities	Direct Cost	Various	10	63		Various	20	2
3	6	Maintenance	Direct Cost	Various	10	2,720		Various	884	3
4	20	Dues & Fees	Direct Cost	Various	10	7,621		Various	2,478	4
5	21	Clerical & General Office	Direct Cost	Various	10	7,474,150	1,110,979	Various	2,429,964	5
6	22	Benefits	Direct Cost	Various	10	245,903		Various	79,947	6
7	26	Insurance	Direct Cost	Various	10	55,572		Various	18,067	7
8	30	Depreciation	Direct Cost	Various	10	23,480		Various	7,634	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		\$ 2,550,247	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						\$	\$				\$	9							
	B. Non-Facility Related*																			
10													10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$				\$	14							
15	TOTALS (line 9+line14)						\$	\$				\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	ASCENSION RESURRECTION LIFE	COUNTY	COOK
---------------	-----------------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0044354

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

81,000

B. General Construction Type:

Exterior

Brick/Concrete

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 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)

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

N/A

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.

N/A

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

☒ 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

☒ 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	281,600	1996	\$ 3,600,000	1
2					2
3	TOTALS	281,600		\$ 3,600,000	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159		1998		\$ 11,729,482	\$ 183,656	40	\$ 250,869	\$ 67,213	\$ 11,729,482	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1999		76,653		12			76,653	9
10	VARIOUS		2000		131,067		11			131,067	10
11	VARIOUS		2001		17,210		11			17,210	11
12	VARIOUS		2002		24,356		12			24,356	12
13	VARIOUS		2003		25,777		9			25,777	13
14	VARIOUS		2004		21,803		13			21,803	14
15	VARIOUS		2005		6,444		8			6,444	15
16	VARIOUS		2006		62,098		18			62,098	16
17	VARIOUS		2008		1,401	51	20	70	19	1,157	17
18	VARIOUS		2012		24,172		10			24,172	18
19											19
20	LYNXSPRING TRIDIUM		2015		15,340	562	20	767	205	7,478	20
21											21
22	PLUMBING DCW BOOSTER		2016		4,251	156	20	213	57	2,022	22
23											23
24	ASPHALT NEW PARKING LOT		2017		46,043	3,370	10	4,604	1,234	34,914	24
25	FIRE PUMP & TRANSFER SWITCH		2017		27,650	1,012	20	1,383	371	11,640	25
26											26
27	Annunciator panel		2018		13,311	488	20	666	178	4,864	27
28											28
29	Compressor Replacement		2019		30,375	1,482	15	2,025	543	14,175	29
30	Repair/Replace Fire Dampers		2019		20,200	1,479	10	2,020	541	12,120	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Vinyl Flooring for Admin	2020	\$ 7,998	\$ 390	15	\$ 533	\$ 143	\$ 3,198	37
38	Carpet Main Floor and Chapel Loft	2020	3,282	1	5	2	1	3,282	38
39	Recommission the existing MELINK Kitchen Exhaust System	2020	145,450	10,648	10	14,545	3,897	94,388	39
40	Fuel Pump for Generator FY20	2020	6,961	255	20	348	93	2,088	40
41	Kitchen Make-up Air Unit FY20	2020	88,086	3,224	20	4,404	1,180	26,424	41
42	Air Cool Chiller FY20	2020	262,920	9,624	20	13,146	3,522	78,876	42
43	Kitchen Dish Machine FY20	2020	14,933	547	20	747	200	4,482	43
44	Boiler System FY20	2020	52,854	1,934	20	2,642	708	15,852	44
45	Mixing Valve FY20	2020	24,286	889	20	1,214	325	7,284	45
46	Vulcan Gas Convection Over, Do	2020	7,773		5			7,773	46
47									47
48	Induction Charge Replacement	2021	3,686		2			3,686	48
49	Induction base heater	2021	6,508	477	10	651	174	3,255	49
50									50
51	Elevator Fire Service Upgrade	2022	107,626	5,253	15	7,175	1,922	28,700	51
52	Ajax Boiler	2022	114,834	5,605	15	7,656	2,051	30,624	52
53	Nurse Call System	2022	224,064	10,936	15	14,938	4,002	59,752	53
54	Interior Signage	2022	23,180	3,394	5	4,636	1,242	18,544	54
55	Exterior Signage	2022	2,807	206	10	281	75	1,124	55
56	Network Project IT - Remove existing wired and wireless network equipment throughout the facility. Install new wired and wireless network throughout the facility, including hardware and cables.	2022	457,266	66,951	5	91,453	24,502	365,812	56
57									57
58									58
59	Telecom Project IT - Remove existing telecommunications equipment throughout the facility. Install new telecommunications throughout the facility.	2022	109,663	16,057	5	21,933	5,876	87,732	59
60									60
61									61
62									62
63	Walk In Freezer Cooling Unit	2022	11,871	869	10	1,187	318	4,748	63
64	Electric Water Heater-Laundry Room	2022	8,771	642	10	877	235	3,508	64
65									65
66	Roof Weatherproofing-Gutters & Downspouts	2023	13,665	667	15	911	244	2,733	66
67	Telecom Project IT Phase 2 - Part 2 of 2022 Telecom Project	2023	10,391	1,902	4	2,598	696	7,794	67
68	Employee Entrance Door & Frame	2023	10,478	512	15	699	187	2,097	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,996,967	\$ 333,239		\$ 455,193	\$ 121,954	\$ 13,071,188	70

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,996,967	\$ 333,239		\$ 455,193	\$ 121,954	\$ 13,071,188	1
2	Chapel Remodel	2024	33,500	1,635	15	2,233	598	4,466	2
3	Courtyard Gazebo	2024	18,670	1,952	7	2,667	715	5,334	3
4	Courtyard Awnings	2024	11,674	1,221	7	1,668	447	3,336	4
5	Chicago Network Project - Part 2 of 2022 Network Project	2024	50,071	7,331	5	10,014	2,683	20,028	5
6	Water Softner	2024	5,910	288	15	394	106	788	6
7	AHU 4 Supply Fan	2024	25,041	1,222	15	1,669	447	3,338	7
8									8
9	CAPITAL REPAINT FACILITY HALLWAYS	2025	36,000	5,271	5	7,200	1,929	7,200	9
10	Courtyard Concrete	2025	14,100	1,032	10	1,410	378	1,410	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	TOTAL (lines 1 thru 33)		\$ 14,191,933	\$ 353,191		\$ 482,448	\$ 129,257	\$ 13,117,088	34

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

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	\$	2,233,930	\$	92,187	\$	125,924	\$ 33,737	Various	\$ 1,996,568	71
72	Current Year Purchases		210,563		44,610		60,935	16,325	Various	60,935	72
73	Fully Depreciated Assets		1,422,694						Various	1,422,694	73
74	Home Office Allocation				7,634		7,634				74
75	TOTALS	\$	3,867,187	\$	144,431	\$	194,493	\$ 50,062		\$ 3,480,197	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)					\$ 21,659,120		
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)					\$ 497,622		
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)					\$ 676,941		
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)					\$ 179,319		
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)					\$ 16,597,285		

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?
16. Rental Amount for movable equipment: \$34,145Description: Nursing \$34,145
- ☐ YES☒ NO
- (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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent
12. /2026\$
13. /2027\$
14. /2028\$

* 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	\$	\$				
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (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

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	

- (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	Service	Schedule V Line & Column Reference	2		3	4		5		6	7	8			
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
							Units	Cost							
1	Licensed Occupational Therapist	10a,3		hrs	\$			\$	592,837	\$			\$	592,837	1
2	Licensed Speech and Language Development Therapist	10a,3		hrs					109,364					109,364	2
3	Licensed Recreational Therapist			hrs											3
4	Licensed Physical Therapist	10a,3		hrs					624,333	2,586				626,919	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 prescripts						747,594				747,594	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs											10
11	Academic Education			hrs											11
12	Other (specify):														12
13	Other (specify):														13
14	TOTAL				\$			\$	1,326,534	\$	750,180		\$	2,076,714	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,369	\$ 5,220,729	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,295,527	33,133,238	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,029	1,463,098	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	94,635	43,660,694	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,431,560	\$ 83,477,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		125,275,441	12
13	Land	8,385,658	68,727,908	13
14	Buildings, at Historical Cost	5,909,792	318,632,245	14
15	Leasehold Improvements, at Historical Cost		1,044,383	15
16	Equipment, at Historical Cost	2,008,515	80,184,781	16
17	Accumulated Depreciation (book methods)	(2,716,448)	(231,197,995)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	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)	\$ 13,587,518	\$ 374,343,329	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,019,078	\$ 457,821,088	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 454,859	\$ 83,079,972	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	571,520	6,998,416	28
29	Short-Term Notes Payable		100,866,380	29
30	Accrued Salaries Payable	437,351	10,756,086	30
	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	623	3,469,121	36
37	IC PAYABLE	625,609	34,345,450	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,089,962	\$ 240,970,957	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		114,059,270	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)	\$	\$ 114,059,270	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,089,962	\$ 355,030,227	46
47	TOTAL EQUITY(page 18, line 24)	\$ 14,929,116	\$ 102,790,862	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,019,078	\$ 457,821,088	48

*(See instructions.)

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,404,256	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,404,256	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,931,823	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)	\$ 1,931,823	17
	B. Transfers (Itemize):		
18	IC TRANSFER	(2,406,963)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,406,963)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 14,929,116	24

* This must agree with page 17, line 47.

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	\$ 21,788,280	1
2	Discounts and Allowances for all Levels	(1,677,998)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,110,282	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	620,136	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 620,136	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	13,551	13
14	Non-Patient Meals	1,773	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	226,447	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,518	19
20	Radiology and X-Ray	44,440	20
21	Other Medical Services		21
22	Laundry	64	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 371,793	23
D. Non-Operating Revenue			
24	Contributions	287,597	24
25	Interest and Other Investment Income***	1,562	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 289,159	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS REVENUE	18,526	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,526	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,409,896	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,586,407	31
32	Health Care	9,895,768	32
33	General Administration	4,506,748	33
B. Capital Expense			
34	Ownership	907,798	34
C. Ancillary Expense			
35	Special Cost Centers	864,934	35
36	Provider Participation Fee	716,418	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,478,073	40
41	Income before Income Taxes (line 30 minus line 40)**	1,931,823	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,931,823	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,747,143.49	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,015,349.69	45
46	MMAI-Medicaid is the Primary Payer	122,078.68	46
47	MMAI-Medicare is the Primary Payer	57,574.31	47
48	Private Pay	3,618,803.05	48
49	Medicare Part A	8,734,439.37	49
50	Other-(specify) INSURANCE	3,814,893.75	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)	\$ 20,110,282	56

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	1,291	1,456	\$ 88,072	\$ 60.49	1
2	Assistant Director of Nursing	750	954	49,297	51.67	2
3	Registered Nurses	56,828	63,233	3,319,219	52.49	3
4	Licensed Practical Nurses	4,538	5,193	227,084	43.73	4
5	CNAs & Orderlies	78,915	86,005	2,449,801	28.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,724	2,082	67,627	32.48	9
10	Activity Assistants	3,697	3,935	68,505	17.41	10
11	Social Service Workers	3,709	4,139	153,235	37.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,323	3,571	109,218	30.58	17
18	Housekeepers	9,854	11,246	211,248	18.78	18
19	Laundry	3,168	3,612	67,759	18.76	19
20	Administrator	1,568	1,822	150,883	82.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,156	3,551	101,495	28.58	23
24	Clerical	6,501	7,782	179,738	23.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	175	175	21,875	125.00	27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,688	1,978	47,936	24.23	31
32	Other Health C:ADMISSIONS	2,378	2,660	78,286	29.43	32
33	Other(specify)PASTORAL	1,816	2,067	60,620	29.33	33
34	TOTAL (lines 1 - 33)	185,078	205,461	\$ 7,451,898	*\$ 36.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	8	385	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	\$ 385		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,424	\$ 637,728	10, 3	50
51	Licensed Practical Nurses	5,470	317,294	10, 3	51
52	Certified Nurse Assistants/Aides	11,190	730,535	10, 3	52
53	TOTAL (lines 50 - 52)	25,084	\$ 1,685,557		53

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
Renee Louise Mills	Administrator		\$ 150,883	Workers' Compensation Insurance	\$	42,556	IDPH License Fee	\$
				Unemployment Compensation Insurance		33,335	Advertising: Employee Recruitment	
				FICA Taxes		557,594	Health Care Worker Background Check	
				Employee Health Insurance		838,792	(Indicate # of checks performed 100)	
				Employee Meals			Patient Background Checks	468
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	16,590
				Dental		(10,759)	Dues & Subscriptions	27,540
				Life		2,780	Home Office Allocation	2,478
				Disability		29,265		
				Pension		133,349		
				Other		7,082		
				Home Office Allocation & Other Offsets		79,947	Less: Public Relations Expense	()
							PAC and Lobbying payments	(995)
							All non-allowable advertising	(5,864)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 150,883					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	1,713,941		\$ 39,749
Corp Office Management Fee			\$ 1,322,149					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 1,322,149					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Non-allowable collection fees	Non-allowable collections		\$ 1,367	N/A			Out-of-State Travel	\$
Language Line	Interpreter		34					
LW Consulting	Reimb & Compliance Consultin		215					
Minmum Data Set Consultant	MDS Consulting		5,110				In-State Travel	2,480
Lester and Rosalie Anixter Center	Disability Services		1,680					
Universal Background Screening	HR Services		9,860					
							Seminar Expense	479
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	TOTAL	\$ 2,959
			\$ 18,266					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number		ASCENSION RESURRECTION LIFE		STATE OF ILLINOIS		Report Period Beginning:		7/1/24		Page 22	
				#		0044354		Ending:		6/30/25	
XX. GENERAL INFORMATION:											
(1) Are nursing employees (RN,LPN,NA) represented by a union'				<u>NO</u>							
(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							
<u>LEADING AGE</u>				<u>15,595</u>							
				<u>15,595</u> 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											
<u>LEADING AGE</u>				<u>995</u>							
				<u>995</u> Total							
(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)											
<u>LEADING AGE</u>				<u>16,590</u>							
				<u>16,590</u> Total							
(5) Indicate the total amount of both disposable and non-disposable incontinent expens and the location of this expense on Sch. V.				\$ <u>85,186</u> Line <u>10</u>							
(6) Have all costs reported on this form been determined using accounting procedure: consistent with prior reports?				<u>YES</u> 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.				\$ <u>716,418</u>							
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'				<u>NO</u> 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 to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V'				<u>YES</u>							
(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?				<u>NO</u> 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.				\$ <u>NONE</u> Has any meal income been offset against related costs? <u>YES</u> Indicate the amount. \$ <u>1,773</u>							
(12) Travel and Transportation											
a. Are there costs included for out-of-state travel?				<u>NO</u>							
If YES, attach a complete explanation.											
b. Do you have a separate contract with the Department to provide medical transportation for residents?				<u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>							
c. What percent of all travel expense relates to transportation of nurses and patients?				<u>N/A</u>							
d. Have vehicle usage logs been maintained?				<u>N/A</u>							
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?				<u>N/A</u>							
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?				<u>N/A</u>							
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.				<u>NO</u> \$ <u>N/A</u>							
(13) Has an audit been performed by an independent certified public accounting firm				<u>YES</u>							
Firm Name:				<u>EY - PERFORMS CONSOLIDATED AUDIT OF ASCENSION HEALTH</u>							
(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?				<u>YES</u>							
(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.				<u>YES</u>							
Attach invoices and a summary of services for all architect and appraisal fees:											