

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0007435</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Central Baptist Village</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</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>4747 N Canfield Ave</u> <u>Norridge</u> <u>60706</u>																																																		
Number City Zip Code																																																		
County: <u>Cook</u>																																																		
Telephone Number: <u>708-452-3711</u> Fax # <u>708-452-3840</u>																																																		
HFS ID Number: _____			<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td colspan="2">(Title) _____</td></tr><tr><td colspan="2">(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Denise A. Leonard, CPA</u> <u>Partner</u></td><td>(Date) _____</td></tr><tr><td colspan="2">(Firm Name & Address) <u>Plante & Moran PLLC</u> <u>1111 Superior Ave Suite 1250 Cleveland, OH 44114</u></td></tr><tr><td colspan="2">(Telephone) <u>(216)-274-6514</u> Fax # <u>(248) 233-7349</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		(Signed) _____		Paid Preparer	(Print Name and Title) <u>Denise A. Leonard, CPA</u> <u>Partner</u>	(Date) _____	(Firm Name & Address) <u>Plante & Moran PLLC</u> <u>1111 Superior Ave Suite 1250 Cleveland, OH 44114</u>		(Telephone) <u>(216)-274-6514</u> Fax # <u>(248) 233-7349</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																												
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Date of Initial License for Current Owners: <u>11/1/1978</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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>			☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other	_____	
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		☐	Other	_____																																														
In the event there are further questions about this report, please contact:																																																		
Name: <u>Lori Altman</u> Telephone Number: <u>(708) 583-8555</u>																																																		
Email Address: _____																																																		

Facility Name & ID Number Central Baptist Village

0007435 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>30</u>	Sheltered Care (SC)	<u>30</u>	<u>10,980</u>	5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>6,824</u>	<u>23,567</u>	<u>7,134</u>	<u>37,525</u>
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC		<u>9,267</u>		<u>9,267</u>
13	DD 16 OR LESS				
14	TOTALS	<u>6,824</u>	<u>32,834</u>	<u>7,134</u>	<u>46,792</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.23%

D. How many bed reserve days during this year were paid by the Department?
None (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)
Meals on Wheels

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 11/19/1978

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/19/1978 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 68 and days of care provided 2,042

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Central Baptist Village # 0007435 Report Period Beginning: 1/1/20 Ending: 12/31/20
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	951,297	96,026	267,092	1,314,415		1,314,415		1,314,415			1
2	Food Purchase		674,496		674,496		674,496	(45,000)	629,496			2
3	Housekeeping	178,836	29,242	45,568	253,646		253,646		253,646			3
4	Laundry	114,926	32,467		147,393		147,393		147,393			4
5	Heat and Other Utilities			206,063	206,063		206,063		206,063			5
6	Maintenance	87,783	107,500	176,808	372,091		372,091	26,721	398,812			6
7	Other (specify):Trash/Security	32,814		31,354	64,168		64,168		64,168			7
8	TOTAL General Services	1,365,656	939,731	726,885	3,032,272		3,032,272	(18,279)	3,013,993			8
	B. Health Care and Programs											
9	Medical Director			37,096	37,096		37,096		37,096			9
10	Nursing and Medical Records	4,494,453	142,608	21,923	4,658,984		4,658,984		4,658,984			10
10a	Therapy	53,396		333,288	386,684		386,684		386,684			10a
11	Activities	233,532	22,068	554	256,154		256,154		256,154			11
12	Social Services	162,495	4,455	900	167,850		167,850		167,850			12
13	CNA Training											13
14	Program Transportation	53,848		2,846	56,694		56,694		56,694			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,997,724	169,131	396,607	5,563,462		5,563,462		5,563,462			16
	C. General Administration											
17	Administrative	350,124			350,124		350,124		350,124			17
18	Directors Fees											18
19	Professional Services			170,509	170,509		170,509		170,509			19
20	Dues, Fees, Subscriptions & Promotions			40,504	40,504		40,504	(3,920)	36,584			20
21	Clerical & General Office Expenses	499,001	83,647	203,735	786,383		786,383	(31,588)	754,795			21
22	Employee Benefits & Payroll Taxes			1,783,933	1,783,933		1,783,933		1,783,933			22
23	Inservice Training & Education											23
24	Travel and Seminar			26,337	26,337		26,337		26,337			24
25	Other Admin. Staff Transportation			549	549		549		549			25
26	Insurance-Prop.Liab.Malpractice			175,233	175,233		175,233		175,233			26
27	Other (specify): Contributions			1,167	1,167		1,167	(1,167)				27
28	TOTAL General Administration	849,125	83,647	2,401,967	3,334,739		3,334,739	(36,675)	3,298,064			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,212,505	1,192,509	3,525,459	11,930,473		11,930,473	(54,954)	11,875,519			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,397,311	1,397,311		1,397,311	(475,724)	921,587			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,864	2,864		2,864		2,864			35
36	Other (specify): Sales Tax			632	632		632	(632)				36
37	TOTAL Ownership			1,400,807	1,400,807		1,400,807	(476,356)	924,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	72,710	458	106,717	179,885		179,885		179,885			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,406	280,406		280,406		280,406			42
43	Other (specify):Non-Allow	244,265	53,126	249,702	547,093		547,093	(547,093)				43
44	TOTAL Special Cost Centers	316,975	53,584	636,825	1,007,384		1,007,384	(547,093)	460,291			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,529,480	1,246,093	5,563,091	14,338,664		14,338,664	(1,078,403)	13,260,261			45

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

	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				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	(57,349)	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	(632)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,167)	27		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				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	(1,019,256)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,078,404)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,078,404)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (4,742)	21	1
2	Bond Fees	(5,792)	21	2
3	Fee Expense A. Genius Fund	(18,795)	43	3
4	Fee Expense R. Genius Trust	(32,457)	43	4
5	Fees Expense A. Frahm Trust	(25,192)	43	5
6	Investment Expenses	(47,313)	43	6
7	Resident Endowment and Assist Fund Expenditures	(60,762)	43	7
8	Creative Arts Fund Expenditures	(151)	43	8
9	Memory Garden Expenditures	(4,214)	43	9
10	Employee Compassion Fund Expenditures	(3,600)	43	10
11	Safety Net Fund Expenditures	(2,049)	43	11
12	Fitness Center Expense	(38,094)	43	12
13	Marketing Salary	(244,265)	43	13
14	Marketing Supplies	(17,075)	43	14
15	Other Marketing Costs	(53,126)	43	15
16	Additional R&M	26,721	06	16
17	Non-Allowable Expense	(21,054)	21	17
18	Non Care Depreciation	(418,375)	30	18
19	Meals on Wheels	(45,000)	2	19
20	Non-Allowable License	(3,920)	20	20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	Total	(1,019,255)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Baptist Village# 0007435

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(45,000)	0	0	0	0	0	0	0	0	0	0	(45,000)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	26,721	0	0	0	0	0	0	0	0	0	0	26,721	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,279)	0	0	0	0	0	0	0	0	0	0	(18,279)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,920)	0	0	0	0	0	0	0	0	0	0	(3,920)	20
21	Clerical & General Office Expenses	(31,588)	0	0	0	0	0	0	0	0	0	0	(31,588)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,167)	0	0	0	0	0	0	0	0	0	0	(1,167)	27
28	TOTAL General Administration	(36,675)	0	0	0	0	0	0	0	0	0	0	(36,675)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,954)	0	0	0	0	0	0	0	0	0	0	(54,954)	29

STATE OF ILLINOIS

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
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(475,724)	0	0	0	0	0	0	0	0	0	0	(475,724) 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):*	(632)	0	0	0	0	0	0	0	0	0	0	(632) 36
37	TOTAL Ownership	(476,356)	0	0	0	0	0	0	0	0	0	0	(476,356) 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):*	(547,093)	0	0	0	0	0	0	0	0	0	0	(547,093) 43
44	TOTAL Special Cost Centers	(547,093)	0	0	0	0	0	0	0	0	0	0	(547,093) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(1,078,403)	0	0	0	0	0	0	0	0	0	0	(1,078,403) 45

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	None		None		None			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

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
None		None		None		

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 Ledger	4Amount	5Cost to Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

* 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	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	See Attached Board of Directors								\$		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 Central Baptist Village # 0007435 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
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						\$	\$			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	TOTALS					\$	\$		\$	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	2017 Bond Series		X	Construction & Renovation		6/15/07	\$ 23,285,000	\$ 18,165,000	11/15/2039	Variable	\$ 1,008,694	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 23,285,000	\$ 18,165,000			\$ 1,008,694	9
	B. Non-Facility Related*											
10	Security Deposit Interest		X								18	10
11	Interest Income		X								(1,008,712)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,008,694)	14
15	TOTALS (line 9+line14)						\$ 23,285,000	\$ 18,165,000			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

* 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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Baptist Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007435

CONTACT PERSON REGARDING THIS REPORT Denise A. Leonard, CPA

TELEPHONE (216)-274-6514 FAX #: (248) 233-7349

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,046

B. General Construction Type: Exterior Brick Frame

Number of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

Retirement Center

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1955	\$ 78,131	1
2					2
3	TOTALS			\$ 78,131	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		1984	1978	\$ 1,924,051	\$	35	\$	\$	\$ 1,924,051	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	741,182		20			741,182	9
10	Various			1979	7,014		20			7,014	10
11	Various			1982	43,548		20			43,548	11
12	Various			1983	121,447		20			121,447	12
13	Various			1984	20,402		20			20,402	13
14	Various			1985	6,955		20			6,955	14
15	Various			1986	3,755		20			3,755	15
16	Various			1988	15,124		20			15,124	16
17	Various			1989	896,689		20			896,689	17
18	Various			1990	1,958,028		20			1,958,028	18
19	Various			1991	104,310		20			104,310	19
20	Various			1992	201,338		20			201,338	20
21	Various			1993	139,141		20			139,141	21
22	Various			1994	115,592		20			115,592	22
23	Various			1995	292,495		20			292,495	23
24	Various			1996	17,999		20			17,999	24
25	Various			1997	74,429		20			74,429	25
26	Various			1998	1,742,405		20			1,742,405	26
27	Various			1999	158,583		20			158,583	27
28	Various			2000	145,352		20			145,352	28
29	Various			2001	69,964		20	3,498	3,498	69,964	29
30	Various			2002	5,489,613		20	274,481	274,481	5,215,132	30
31	Various			2003	8,252		20	413	413	7,427	31
32	Various			2004	68,635		20	3,432	3,432	58,340	32
33	Various			2005	45,687		20	2,284	2,284	36,550	33
34	Various			2006	954,222		20	47,711	47,711	715,667	34
35	Various			2007	2,610,864		20	130,543	130,543	1,827,605	35
36	Various			2008	209,097		20	10,455	10,455	135,913	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

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	Various	2009	\$ 120,177	\$	20	\$ 6,009	\$ 6,009	\$ 72,106	37
38	Various	2010	238,375		20	11,919	11,919	131,106	38
39	Various	2011	383,853		20	19,193	19,193	191,927	39
40	Various	2012	168,119		20	8,406	8,406	75,654	40
41	Various	2013	44,715		20	2,236	2,236	17,886	41
42	Various	2014	209,933		20	10,497	10,497	73,477	42
43									43
44									44
45									45
46									46
47	Financial Statement Depreciation- Central Baptist Village			978,936			(978,936)		47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 19,351,345	\$ 978,936		\$ 531,075	\$ (447,861)	\$ 17,358,591	70

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

Facility Name & ID Number Central Baptist Village

0007435

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,351,345	\$ 978,936		\$ 531,075	\$ (447,861)	\$ 17,358,591	1
2	Hitchcock Design/Memory Garden (8,436.37)	2015	4,556		20	228	228	1,367	2
3	Stone Forest/Memory Garden Fountain (3,243.00)	2015	1,751		20	88	88	525	3
4	Hitchcock Design/Memory Garden (5,057.58)	2015	2,731		20	137	137	819	4
5	Crg Co/Chapel Restroom Update (4,250.00)	2015	2,295		20	115	115	689	5
6	Stone Forest/Memory Garden (4,743.00)	2015	2,561		20	128	128	768	6
7	Anderson Lock/Card Reader Employee Patio (3,475.32)	2015	1,877		20	94	94	563	7
8	Manas Torcom/Café Floor (4,673.00)	2015	2,523		20	126	126	757	8
9	Thornapple Landscapes/Memory Garden (51,030.78)	2015	27,557		20	1,378	1,378	8,267	9
10	Thornapple Landscapes/Memory Garden (36,712.09)	2015	19,825		20	991	991	5,948	10
11	Thornapple Landscapes/Memory Garden (60,918.74)	2015	32,896		20	1,645	1,645	9,869	11
12	Thornapple Landscapes/Memory Garden (16,517.96)	2015	8,920		20	446	446	2,676	12
13	Keganivo Group/Memory Garden (4,500.00)	2015	2,430		20	122	122	729	13
14	Dominick Fedele/Tree Work (4,950.00)	2015	2,673		20	134	134	802	14
15	De Marr Sealcoating/Sealcoat Parking Lot (13,459.96)	2015	7,268		20	363	363	2,180	15
16	Stanton Mechanical/Hot Water Boiler (6,767.00)	2015	3,654		20	183	183	1,096	16
17									17
18	Elevator Technicians/Elevators (2,500.00)	2015	1,350		20	68	68	405	18
19	Stanton Mechanical/Hot Water Boiler (16,200.00)	2015	8,748		20	437	437	2,624	19
20	Crestwood/Gp Upgrade (2,802.95)	2015	1,514		20	76	76	454	20
21	Roc'S Plumbing/Drain Pipes (Board Room) (8,875.00)	2015	4,793		20	240	240	1,438	21
22	Roc'S Plumbing/Pavilion Ejector Pumps	2015	5,800		20	290	290	1,740	22
23	Anderson Lock/Admin Door	2015	3,475		20	174	174	1,043	23
24	Anderson Lock/Np Entry Door	2015	3,475		20	174	174	1,043	24
25	Anderson Lock/Digital Keypads	2015	4,671		20	234	234	1,401	25
26	Roc'S Plumbing/Hot Water Storage Tanks	2015	10,000		20	500	500	3,000	26
27	Anderson Lock/Lower Level Door Closures	2015	2,860		20	143	143	858	27
28	Centimark/Roof Repair	2015	4,950		20	248	248	1,485	28
29	Keganivo Group/Np Resident Interactive Area	2015	7,841		20	392	392	2,352	29
30	Roc'S Plumbing/Hot Water Storage Tank	2015	22,843		20	1,142	1,142	6,853	30
31	Schamback/Interactive Area-Demo/Electric/Floor/Paint/Drywall	2015	54,835		20	2,742	2,742	16,451	31
32	Anderson Lock/Np Interactive Area	2015	2,545		20	127	127	764	32
33	Westside Mechanical/Heat Pumps (2,503.24)	2015	591		20	30	30	177	33
34	TOTAL (lines 1 thru 33)		\$ 19,615,153	\$ 978,936		\$ 544,266	\$ (434,670)	\$ 17,437,733	34

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

Facility Name & ID Number Central Baptist Village

0007435

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,615,153	\$ 978,936		\$ 544,266	\$ (434,670)	\$ 17,437,733	1
2	Manas Torcom/Unit Flooring (4,167.46)	2015	984		20	49	49	295	2
3	Emcor Services/Heat Pumps (20,180.00-\$6,448)	2015	2,852		20	143	143	856	3
4	Nurse Call System	2015	2,569		20	128	128	771	4
5	Anderson Lock/Lower Level Auto Door Opener (2,614)	2016	1,303		20	65	65	326	5
6	Affordable Tuckpointing/Tuckpointing (3,710)	2016	1,848		20	92	92	462	6
7	Stanton Mechanical/Control System (124,200)	2016	61,913		20	3,096	3,096	15,478	7
8	Stanton Mechanical/Chiller	2016	133,800		20	6,690	6,690	33,450	8
9	Stanton Mechanical/Kitchen Make Up Air Handler	2016	73,890		20	3,695	3,695	18,473	9
10	Waukegan Roofing/Upper-Lower Roof	2016	201,062		20	10,053	10,053	50,266	10
11	Stanton Mechanical/Duct Work On Roof	2016	12,609		20	630	630	3,152	11
12	Krause Electrical/Kitchen Make Up Air	2016	14,998		20	750	750	3,750	12
13	Waukegan Roofing/Upper-Lower Roof	2016	134,260		20	6,713	6,713	33,565	13
14	Stanton Mechanical/Air Roof Top Replace	2016	9,000		20	450	450	2,250	14
15	Stanton Mechanical/Upper-Lower Roof	2016	12,221		20	611	611	3,055	15
16	Stanton Mechanical/Upper-Lower Roof	2016	4,645		20	232	232	1,161	16
17	Stanton Mechanical/Upper-Lower Roof	2016	3,525		20	176	176	881	17
18	Stanton Mechanical/Air Roof Top Replace	2016	5,221		20	261	261	1,305	18
19	Waukegan Roofing/Upper-Lower Roof	2016	3,450		20	173	173	863	19
20	Np Lounge	2016	108,091		20	5,405	5,405	27,023	20
21	Fox Valley/Magnetic Door Holders	2016	2,720		20	136	136	680	21
22	Stanton Mechanical/Control System	2016	7,454		20	373	373	1,864	22
23	Air Roof Top Replacement	2016	28,123		20	1,406	1,406	7,031	23
24	Concrete Repair/Retaining Wall	2016	6,480		20	324	324	1,620	24
25	1st Floor Painting	2017	16,994		20	850	850	3,399	25
26	1st Floor Carpeting	2017	87,758		20	4,388	4,388	17,552	26
27	Admin Bathroom Remodel	2017	1,423		20	71	71	285	27
28	Concrete Patio	2017	10,099		20	505	505	2,020	28
29	Rehab Room Remodel - Design and architect drawings, finishes sele	2017	6,739		20	337	337	1,348	29
30	Rehab Room Remodel - Shelving, Storage, & Mirrors	2017	3,897		20	195	195	779	30
31	1st Floor Carpeting	2017	1,234		20	62	62	247	31
32	Landscaping	2017	11,281		20	564	564	2,256	32
33	Landscaping Lighting	2017	4,462		20	223	223	892	33
34	TOTAL (lines 1 thru 33)		\$ 20,592,056	\$ 978,936		\$ 593,111	\$ (385,825)	\$ 17,675,085	34

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

Facility Name & ID Number Central Baptist Village

0007435

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 20,592,056	\$ 978,936		\$ 593,111	\$ (385,825)	\$ 17,675,085	1
2	Foundation Repair	2017	1,655		20	83	83	331	2
3	Lot Reseal	2017	3,428		20	282	282	1,127	3
4	Basement Tile	2017	2,398		20	120	120	480	4
5	Heat Pump - Nursing	2017	4,505		20	225	225	901	5
6	Fire Alarm Panel	2017	1,495		20	75	75	299	6
7	Dryvit Sheltered Care	2018	8,835		20	442	442	1,325	7
8	Tuckpointing	2018	910		20	45	45	136	8
9	Foundation Work	2018	3,091		20	155	155	464	9
10	Front Entry Canopy	2018	44,813		20	2,241	2,241	6,722	10
11	Boiler Replacement	2018	44,815		20	2,241	2,241	6,722	11
12	Terrace Carpet	2018	36,000		20	1,800	1,800	5,400	12
13	Paint Hallways Sheltered Care	2018	13,880		20	694	694	2,082	13
14	Landscaping - Entryway	2018	4,003		20	200	200	600	14
15	HVAC	2018	2,174		20	109	109	326	15
16	Carpet Replace Sheltered Care	2018	1,920		20	96	96	288	16
17	Exit Doors	2018	843		20	42	42	126	17
18	Faraday Panel	2018	27,836		20	1,392	1,392	4,175	18
19	Fire Damper	2018	2,234		20	112	112	335	19
20	Skilled Nursing Unit Door	2018	2,419		20	121	121	363	20
21	Patient Wander Management System	2018	7,955		20	398	398	1,193	21
22	Nurse Call Patient Stations	2018	5,011		20	251	251	752	22
23	Cooling Tower (Roof)	2018	17,791		20	890	890	2,669	23
24	Rehab Room Renovation - Labor and materials for demolition, cons	2018	30,978		20	1,549	1,549	4,647	24
25	Rehab Room Renovation - Curtains	2018	2,630		20	131	131	394	25
26	Rehab Room Renovation - Flooring	2018	1,704		20	85	85	256	26
27	Rehab Room Renovation - Lighting	2018	234		20	12	12	35	27
28	Rehab Room Renovation - Electrical	2018	454		20	23	23	68	28
29	Rehab Room Renovation - Plumbing	2018	542		20	27	27	81	29
30	Rehab Room Renovation - Cabinetry	2018	23		20	1	1	3	30
31	Rehab Room Renovation - Design	2018	1,094		20	55	55	164	31
32	Rehab Room Renovation - Wall Covering	2018	246		20	12	12	37	32
33	Rehab Room Renovation - Rehab Supplies, ie ballet bar, orientatio	2018	1,690		20	84	84	253	33
34	TOTAL (lines 1 thru 33)		\$ 20,869,658	\$ 978,936		\$ 607,101	\$ (371,835)	\$ 17,717,841	34

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

Facility Name & ID Number Central Baptist Village

0007435

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 20,869,658	\$ 978,936		\$ 607,101	\$ (371,835)	\$ 17,717,841	1
2	<u>Elevator Replacement- Including Electric, Locks, Paint, Permits</u>	2019	295,680		20	14,784	14,784	29,568	2
3	<u>Communication/Sound System Throughout Entire Facility (\$35,560)</u>	2019	17,726		20	886	886	1,773	3
4	<u>Automatic Doors Openers- Loading Dock (\$3,388)</u>	2019	1,689		20	84	84	169	4
5	<u>Automatic Doors Openers- Main Hallway (\$3,499)</u>	2019	1,744		20	87	87	174	5
6	<u>Automatic Doors Openers- Sun Room (\$4,873)</u>	2019	2,429		20	121	121	243	6
7	<u>Wander Management System Expansion- Entire Facility (\$38,636)</u>	2019	38,636		20	1,932	1,932	3,864	7
8	<u>Conference Room Near Front Entrance- Paint and Design (\$6,161)</u>	2019	3,071		20	154	154	307	8
9	<u>Chapel Restroom Updates- Plumbing, Flooring, Faucets Update (\$</u>	2019	5,892		20	295	295	589	9
10	<u>Curtain Replacements- Multipurpose Room, Near Commons (\$5,31</u>	2019	2,651		20	133	133	265	10
11	<u>Keypads and Door Locks Nursing Pavilion (\$2,921)</u>	2019	2,921		20	146	146	292	11
12	<u>Keypads and Door Locks Loading Dock (\$2,815)</u>	2019	1,403		20	70	70	140	12
13	<u>Fire Safety System- Dampers/Actuators Throughout Entire Facility</u>	2019	5,045		20	252	252	505	13
14	<u>Wi-Fi System Upgrade- Entire Facility- Access Points (\$64,611)</u>	2019	32,208		20	1,610	1,610	3,221	14
15	<u>Carpeting Replacement on the Lower Level Employee Lounge (\$12</u>	2019	6,087		20	304	304	609	15
16	<u>Administrative Conference Room Renovation - Paint, Signage, Desi</u>	2019	3,707		20	185	185	371	16
17	<u>Flooring At Front Entrance To Facility (\$6,456)</u>	2019	3,218		20	161	161	322	17
18	<u>Carpeting Replacement in Shelter Care (\$3,187)</u>	2019	3,187		20	159	159	319	18
19	<u>Boiler Room Piping and Boiler Repairs - Nursing Pavilion (\$3,699)</u>	2019	3,699		20	185	185	370	19
20	<u>Laundry Room Flooring (\$6,869)</u>	2019	3,424		20	171	171	342	20
21	<u>NP Unit Flooring (\$2,827)</u>	2019	2,828		20	141	141	283	21
22	<u>Sunroom Floor TT (\$4,429)</u>	2019	4,429		20	221	221	443	22
23	<u>Bldg Automation System (\$17,020)</u>	2019	8,484		20	424	424	848	23
24	<u>Chapel Sound System (\$3,381)</u>	2019	1,685		20	84	84	169	24
25	<u>Cabinets-Life Enrich Office (\$4,439)</u>	2019	2,213		20	111	111	221	25
26	<u>Dryvit Caulking Refinish (\$7,056)</u>	2019	1,469		20	73	73	147	26
27	<u>Skilled Nursing Area- Rehab Heat Exchanger (4,888)</u>	2019	4,888		20	244	244	489	27
28	<u>Front Entrance Canopy (\$4,531)</u>	2019	2,259		20	113	113	226	28
29	<u>Water Softener For Water System (\$2,795)</u>	2019	1,393		20	70	70	139	29
30	<u>RTU- Commons Center (\$23,785)</u>	2019	4,953		20	248	248	495	30
31	<u>Replace Blinds Shelter Care (\$3,270)</u>	2019	3,270		20	164	164	327	31
32	<u>Cabinetry For Snack Shop Area (\$5,975)</u>	2019	2,978		20	149	149	298	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,344,925	\$ 978,936		\$ 630,865	\$ (348,071)	\$ 17,765,367	34

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

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 12E, Carried Forward		\$ 21,344,925	\$ 978,936		\$ 630,865	\$ (348,071)	\$ 17,765,367	1
2	Elevator Repairs and Modernization (Doors/Lights/Electrical)	2020	109,627		20	5,481	5,481	5,481	2
3	For the Dock Area of the Shelter Care Area								3
4	Flooring & Carpeting Inside Shelter Care Resident Rooms	2020	5,225		20	261	261	261	4
5	New RTU/HVAC System For Shelter Care Area of Facility	2020	53,873		20	2,694	2,694	2,694	5
6	New Nurse Call System For Shelter Care Area of Facility	2020	9,846		20	492	492	492	6
7	Duct Work & Dampers (Air Flow)-Boiler Room/Kitchen	2020	5,187		20	259	259	259	7
8	Cubicle Curtains-Semi-Pvt Resident Rooms-Skilled Area	2020	71,456		20	3,573	3,573	3,573	8
9	Drybit & Caulking-Ext. Walls of Facility-Shelt.Care (\$7,056)	2020	1,469		20	73	73	73	9
10	Drybit & Caulking-Ext. Walls of Facility-Shelt.Care(\$14,112)	2020	2,939		20	147	147	147	10
11	Flue Extensions -Whole Shelter Care Area (\$6,364)	2020	1,325		20	66	66	66	11
12	LED Lights Upgrade:Common Areas Skilled Nurs. (\$5,125)	2020	1,067		20	53	53	53	12
13	Sewer Caps for Plumbing System- Parking Lot Main (\$2,750)	2020	1,371		20	69	69	69	13
14	Asphalt/Sealcoating- Shared Parking Lot (\$3,260)	2020	1,625		20	81	81	81	14
15	Asphalt/Sealcoating- Shared Parking Lot (\$3,410)	2020	1,700		20	85	85	85	15
16	Rear Lawn- Rentention Pond- Retaining Wall (\$7,852)	2020	3,914		20	196	196	196	16
17	Re-Shingle Roof-Garage Serving Entire Facility (\$12,775)	2020	6,368		20	318	318	318	17
18	Exterior Lighting- Outdoor Lights on Property (7,503)	2020	3,740		20	187	187	187	18
19	Water Softening System-Kitchen (\$2,688)	2020	1,340		20	67	67	67	19
20	Added Concrete Ramp-Skilled Nurs. Emergency Exit (\$2,646)	2020	1,319		20	66	66	66	20
21	Negative Air Pressure System-Multipurpose Room-(\$3,920)	2020	1,954		20	98	98	98	21
22	Added Concrete Ramp-Skilled Nurs. Emergency Exit (\$2,780)	2020	1,386		20	69	69	69	22
23	Sidewalk Railings For SNF Emergency Exit Area (\$2,900)	2020	1,454		20	73	73	73	23
24	Sidewalk Railings For SNF Emergency Exit Area (\$2,900)	2020	1,454		20	73	73	73	24
25	LED Lights Upgrade:Common Areas Skilled Nurs.(\$4,975)	2020	2,480		20	124	124	124	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,637,045	\$ 978,936		\$ 645,471	\$ (333,465)	\$ 17,779,973	34

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

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 12F, Carried Forward		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	34

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

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 12G, Carried Forward		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	34

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

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 12H, Carried Forward		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$21,637,045	\$978,936		\$645,471	\$ (333,465)	\$17,779,973	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,636,512	\$	\$263,651	\$263,651	10	\$1,965,290	71
72	Current Year Purchases	82,840		8,284	8,284	10	8,284	72
73	Fully Depreciated Assets	398,930				10	398,930	73
74								74
75	TOTALS	\$3,118,282	\$	\$271,935	\$271,935		\$2,372,504	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	Facility	See Attached Schedules	Various	\$180,361	\$	\$4,182	\$4,182	5	\$167,815	76
77										77
78										78
79										79
80	TOTALS			\$180,361	\$	\$4,182	\$4,182		\$167,815	80

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$25,013,819
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$978,936
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$921,588
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(57,348)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$20,320,292

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	See Attached Schedules	\$15,704,253	\$418,375	\$13,103,436	86
87	Note (expense is excluded from PG3 & 4)				87
88					88
89					89
90					90
91	TOTALS	\$15,704,253	\$418,375	\$13,103,436	91

G. Construction-in-Progress

	Description	Cost	
92	NP Complete Renovation/	\$265,590	92
93	NP Lounge Furniture		93
94	NP Containment/Ventillation		94
95	Doors, Land Sale	\$265,590	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 2,864 Description: Vending Machine \$2,864
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS

(d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
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.

HFS 3745 (N-4-99)

IL478-2471

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	\$	1,738	\$ 122,567	\$	1,738	\$ 122,567	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		2,252	91,133		2,252	91,133	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		1,819	119,588		1,819	119,588	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	72,710					72,710	8
9	Pharmacy	V39	# of prescripts				94,128		94,128	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					12,589		12,589	12
13	Other (specify): BILLABLE SUPPLIES	V39					458		458	13
14	TOTAL			\$ 72,710	5,808	\$ 333,288	\$ 107,175	5,808	\$ 513,173	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,342,962	\$	1
2	Cash-Patient Deposits	39,491		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,881,095	_____	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	226,411		6
7	Other Prepaid Expenses	78,443		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	3,123,690		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,692,092	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	38,900,715		12
13	Land	285,820		13
14	Buildings, at Historical Cost	29,120,093		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	11,323,290		16
17	Accumulated Depreciation (book methods)	(21,230,034)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		_____	20
21	Restricted Funds	2,492,880		21
22	Other Long-Term Assets (spe See Attached	265,590		22
23	Other(specify): See Attached	144,475		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 61,302,829	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 67,994,921	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 798,527	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,034,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,414	_____	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	2,137,347		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,975,452	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	18,165,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	147,290		43
44	See Attached			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 18,312,290	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,287,742	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 45,707,180	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 67,994,921	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 44,507,888	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 44,507,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,928,309	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) Contrib, Changes in Perpetual Trust	(219,773)	15
16	Other (describe) Value, Changes in Net Asets		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,708,536	17
	B. Transfers (Itemize):		
18	ILU Net Asset Activity For The Year	(509,244)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (509,244)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 45,707,180	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Central Baptist Village

0007435

Report Period Beginning: 1/1/20

Ending:

12/31/20

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,285,768	1
2	Discounts and Allowances for all Levels	(670,796)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,614,972	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	839,775	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 839,775	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	127	12
13	Barber and Beauty Care	5,326	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	70,739	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,125	19
20	Radiology and X-Ray	8,243	20
21	Other Medical Services	25,727	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,287	23
	D. Non-Operating Revenue		
24	Contributions	881,457	24
25	Interest and Other Investment Income***	872,866	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,754,323	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		941,616	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 941,616	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,266,973	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,032,272	31
32	Health Care	5,563,462	32
33	General Administration	3,334,739	33
	B. Capital Expense		
34	Ownership	1,400,807	34
	C. Ancillary Expense		
35	Special Cost Centers	726,978	35
36	Provider Participation Fee	280,406	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,338,664	40
41	Income before Income Taxes (line 30 minus line 40)**	1,928,309	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,928,309	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 433,199	44
45	Private Pay - Net Inpatient Revenue	8,578,388	45
46	Medicare - Net Inpatient Revenue	1,241,332	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	2,999,104	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(637,051)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,614,972	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,024	\$ 144,399	\$ 71.34	1
2	Assistant Director of Nursing	1,928	2,080	89,565	43.06	2
3	Registered Nurses	35,061	36,632	1,503,432	41.04	3
4	Licensed Practical Nurses	12,677	13,359	452,678	33.89	4
5	CNAs & Orderlies	84,418	88,076	1,654,151	18.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,883	6,268	126,106	20.12	8
9	Activity Director	1,249	1,294	42,104	32.54	9
10	Activity Assistants	11,148	11,850	191,428	16.15	10
11	Social Service Workers	5,183	5,334	162,495	30.46	11
12	Dietician					12
13	Food Service Supervisor	7,744	8,090	133,882	16.55	13
14	Head Cook	29,384	31,124	817,415	26.26	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,972	5,165	87,783	17.00	17
18	Housekeepers	11,885	12,469	178,836	14.34	18
19	Laundry	7,803	8,037	114,926	14.30	19
20	Administrator	4,048	4,048	350,124	86.49	20
21	Assistant Administrator					21
22	Other Administrative	9,624	10,347	401,118	38.77	22
23	Office Manager					23
24	Clerical	5,639	5,909	97,883	16.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,008	2,080	52,177	25.09	31
32	Other Health Care (Secur/Trans)	26,951	28,135	684,712	24.34	32
33	Other(Mktg)	4,990	5,245	244,265	46.57	33
34	TOTAL (lines 1 - 33)	274,619	287,566	\$ 7,529,479 *	\$ 26.18	34

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	Monthly Fees	\$ 57,000	V01-03	35
36	Medical Director	Monthly Fees	37,096	V09-03	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	Monthly Fees	891	V11-03	44
45	Social Service Consultant	Monthly Fees	1,446	V12-03	45
46	Other(specify) Morrison Mgt- Diet	Monthly Fees	35,399	V01-03	46
47	Morrison Mgmt Fee- Maintenance	Monthly Fees	34,467	V06-03	47
48	Morrison Mgmt Fee- Housekeeping	Monthly Fees	26,628	V03-03	48
49	TOTAL (lines 35 - 48)		\$ 192,927		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	606	21,922	V10-03	52
53	TOTAL (lines 50 - 52)	606	\$ 21,922		53

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

** See instructions.

