

		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>0004630</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Christian Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</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>1507 7th Street</u> <u>Lincoln</u> <u>62656</u>																									
Number City Zip Code																									
County: <u>Logan</u>																									
Telephone Number: <u>217-732-2189</u> Fax # <u>217-732-1904</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Chuck Schmitz</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) () Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Chuck Schmitz</u>	(Title) <u>CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Chuck Schmitz</u>																								
	(Title) <u>CFO</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) () Fax # ()																								
Date of Initial License for Current Owners: <u>9/1/1965</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Kenna Hudson</u> Telephone Number: <u>314-587-7924</u>																									
Email Address: _____																									

Facility Name & ID Number Christian Nursing Home

0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	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>124</u>	Skilled (SNF)	<u>124</u>	<u>45,384</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>124</u>	TOTALS	<u>124</u>	<u>45,384</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>24,126</u>	<u>8,131</u>	<u>4,879</u>	<u>37,136</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,126</u>	<u>8,131</u>	<u>4,879</u>	<u>37,136</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.83%

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, Lawn & Maint Care, Housekeeping & Laundry Services for IL Residents

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 9/1/1995

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 124 and days of care provided 3,266

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/20 Fiscal Year: 6/30/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	276,975	41,016	19,198	337,189		337,189		337,189			1
2	Food Purchase		274,747		274,747		274,747	(2,333)	272,414			2
3	Housekeeping	187,289	25,421		212,710		212,710		212,710			3
4	Laundry	25,058	1,599		26,657		26,657		26,657			4
5	Heat and Other Utilities			175,660	175,660		175,660	(26,570)	149,090			5
6	Maintenance	65,871	18,228	111,713	195,812		195,812	3,046	198,858			6
7	Other (specify):* Trash			10,172	10,172		10,172		10,172			7
8	TOTAL General Services	555,193	361,011	316,743	1,232,947		1,232,947	(25,857)	1,207,090			8
	B. Health Care and Programs											
9	Medical Director			31,200	31,200		31,200		31,200			9
10	Nursing and Medical Records	3,299,595	130,526	245,563	3,675,684		3,675,684	(6,923)	3,668,761			10
10a	Therapy			764,787	764,787		764,787		764,787			10a
11	Activities	98,780	10,428	3,989	113,197		113,197		113,197			11
12	Social Services	251,010	4,731	11,854	267,595		267,595		267,595			12
13	CNA Training											13
14	Program Transportation			13,485	13,485		13,485	(5,750)	7,735			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,649,385	145,685	1,070,878	4,865,948		4,865,948	(12,673)	4,853,275			16
	C. General Administration											
17	Administrative	132,209		561,368	693,577		693,577	(447,800)	245,777			17
18	Directors Fees											18
19	Professional Services			98,953	98,953		98,953	(3,071)	95,882			19
20	Dues, Fees, Subscriptions & Promotions			28,978	28,978		28,978	4,328	33,306			20
21	Clerical & General Office Expenses	229,571	20,365	536,924	786,860		786,860	(75,221)	711,639			21
22	Employee Benefits & Payroll Taxes			891,489	891,489		891,489	79,185	970,674			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,272	4,272		4,272	17,789	22,061			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			178,664	178,664		178,664	37,219	215,883			26
27	Other (specify):* Marketing	126,005	8,245	39,760	174,010		174,010	(174,010)				27
28	TOTAL General Administration	487,785	28,610	2,340,408	2,856,803		2,856,803	(561,581)	2,295,222			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,692,363	535,306	3,728,029	8,955,698		8,955,698	(600,111)	8,355,587			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			681,557	681,557		681,557	59,154	740,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,911	180,911		180,911	(105,924)	74,987			32
33	Real Estate Taxes			5,515	5,515		5,515	(5,515)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,810	15,810		15,810		15,810			35
36	Other (specify):* Def Financing Costs			1,551	1,551		1,551		1,551			36
37	TOTAL Ownership			885,344	885,344		885,344	(52,285)	833,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			361,214	361,214		361,214	(17,246)	343,968			39
40	Barber and Beauty Shops			10,791	10,791		10,791		10,791			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			290,467	290,467		290,467		290,467			42
43	Other (specify):* Villa/Duplex/Congl	470,287		945,918	1,416,205		1,416,205	(1,416,205)				43
44	TOTAL Special Cost Centers	470,287		1,608,390	2,078,677		2,078,677	(1,433,451)	645,226			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,162,650	535,306	6,221,763	11,919,719		11,919,719	(2,085,847)	9,833,872			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,059)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,150)	21		5
6	Rented Facility Space	(411)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(105,924)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,863)	10		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	(306)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(97,173)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(324,825)	21		24
25	Fund Raising, Advertising and Promotional	(174,010)	27		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	(1,574,218)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,293,939)		\$	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)	208,092	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 208,092		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,085,847)		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	Transportation	\$ (5,750)	14	1
2	Garden Villa/Duplex/Congregate	(1,520,583)	43	2
3	Real Estate Tax	(5,515)	33	3
4	Miscellaneous Revenue	(12,727)	21	4
5	Vending Revenue	(1,274)	2	5
6	Lobbying Expense	(435)	20	6
7				7
8	Medical Records Revenue	(60)	10	8
9	Cable TV Expense	(27,874)	5	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(1,574,218)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,333)	0	0	0	0	0	0	0	0	0	0	(2,333)	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	(28,285)	1,715	0	0	0	0	0	0	0	0	0	(26,570)	5
6	Maintenance	0	3,046	0	0	0	0	0	0	0	0	0	3,046	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(30,618)	4,761	0	0	0	0	0	0	0	0	0	(25,857)	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	(6,923)	0	0	0	0	0	0	0	0	0	0	(6,923)	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	(5,750)	0	0	0	0	0	0	0	0	0	0	(5,750)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(12,673)	0	0	0	0	0	0	0	0	0	0	(12,673)	16
	C. General Administration													
17	Administrative	0	(447,800)	0	0	0	0	0	0	0	0	0	(447,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(97,173)	94,102	0	0	0	0	0	0	0	0	0	(3,071)	19
20	Fees, Subscriptions & Promotions	(435)	4,763	0	0	0	0	0	0	0	0	0	4,328	20
21	Clerical & General Office Expenses	(347,008)	271,787	0	0	0	0	0	0	0	0	0	(75,221)	21
22	Employee Benefits & Payroll Taxes	0	79,185	0	0	0	0	0	0	0	0	0	79,185	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,789	0	0	0	0	0	0	0	0	0	17,789	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	37,219	0	0	0	0	0	0	0	0	0	37,219	26
27	Other (specify):*	(174,010)	0	0	0	0	0	0	0	0	0	0	(174,010)	27
28	TOTAL General Administration	(618,626)	57,045	0	0	0	0	0	0	0	0	0	(561,581)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(661,917)	61,806	0	0	0	0	0	0	0	0	0	(600,111)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	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	0	59,154	0	0	0	0	0	0	0	0	0	59,154	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(105,924)	0	0	0	0	0	0	0	0	0	0	(105,924)	32
33	Real Estate Taxes	(5,515)	0	0	0	0	0	0	0	0	0	0	(5,515)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(111,439)	59,154	0	0	0	0	0	0	0	0	0	(52,285)	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	(17,246)	0	0	0	0	0	0	0	0	0	(17,246)	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):*	(1,520,583)	104,378	0	0	0	0	0	0	0	0	0	(1,416,205)	43
44	TOTAL Special Cost Centers	(1,520,583)	87,132	0	0	0	0	0	0	0	0	0	(1,433,451)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,293,939)	208,092	0	0	0	0	0	0	0	0	0	(2,085,847)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board of Directors Attachment						

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Horizons	100.00%	\$ 1,715	\$ 1,715	1
2	V	6	Maintenance				3,046	3,046	2
3	V	17	Administrative	561,368			113,568	(447,800)	3
4	V	19	Professional Services				94,102	94,102	4
5	V	21	Clerical				217,757	217,757	5
6	V	22	Employee Benefits				79,185	79,185	6
7	V	20	Dues & Subscriptions				4,763	4,763	7
8	V	24	Travel & Seminar				17,789	17,789	8
9	V	26	Insurance				37,219	37,219	9
10	V	30	Depreciation				59,154	59,154	10
11	V	21	Other Administrative Expense				54,030	54,030	11
12	V	43	Independent Living				104,378	104,378	12
13	V	39	Pharmacy Services	323,286	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	306,040	(17,246)	13
14	Total			\$ 884,654			\$ 1,092,746	\$ * 208,092	14

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

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	This workpaper is N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	This workpaper is N/A								\$		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 Christian Nursing Home # 0004630 Report Period Beginning: 7/1/19 Ending: 6/30/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
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		This workpaper is N/A				\$	\$			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							\$		\$			\$	1
2	Illinois Finance Authority Series 2010	X		Refinance Debt		7/31/10	2,000,000	915,210	5/15/27	6.1300	25,225	2	
3	Illinois Finance Authority Series 2016	X		Refinance Debt		3/1/16	2,780,395	6,805,640	5/15/40	5.0000	154,513	3	
4	Illinois Finance Authority Series 2018	X		Refinance Debt		12/12/18	445,300	445,300	5/15/40	5.0000	9,935	4	
5	Bond Fund	X		Debt Relocation	Various	Various	843,874	456,011	6/30/32	Various	(8,762)	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 6,069,569	\$ 8,622,162			\$ 180,911	9	
	B. Non-Facility Related*												
10	Interest Income Offset										(105,924)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (105,924)	14	
15	TOTALS (line 9+line14)						\$ 6,069,569	\$ 8,622,162			\$ 74,987	15	

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	8		
	2016	9		
	2017	10		
	2018	11		
	2019	12		
			FOR BHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 314-587-7916

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 12-623-005-00	See attached tax bills	\$ 350.50	\$
2. 12-036-032-00	See attached tax bills	\$ 308.52	\$
3. 12-036-037-00	See attached tax bills	\$ 3,097.86	\$
4. 12-036-031-00	See attached tax bills	\$ 1,166.70	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 4,923.58	\$

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? X YES NO

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

C. Tax Bills

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

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

A. Square Feet:

63,353

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

Apartments

Congregate Building

Duplexes

AL Villa

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	43,560		\$ 83,965	1
2	Home Office Allocation			9,567	2
3	TOTALS	43,560		\$ 93,532	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	100		1965	1965	\$ 1,027,427	\$	54	\$	\$	1,025,867	4
5	24		2000	2000	1,279,292	31,982	40	31,982		631,650	5
6			2016	2016	4,191,053	104,776	40	104,776		401,643	6
7											7
8	Home Office Allocation				125,758	3,465		3,465		71,818	8
	Improvement Type**										
9	Various		1975		22,324		Various			22,324	9
10	Various		1976		754		Various			754	10
11	Various		1979		11,989	266	Various	266		10,945	11
12	Various		1980		36,891		Various			36,891	12
13	Various		1982		2,875		Various			2,875	13
14	Various		1983		51,143		Various			51,143	14
15	Various		1985		7,800	186	Various	186		7,782	15
16	Various		1986		341		Various			341	16
17	Various		1987		626		Various			626	17
18	Various		1988		3,966		Various			3,966	18
19	Various		1989		475		Various			475	19
20	Various		1991		711	20	Various	20		591	20
21	Various		1992		15,915		Various			15,915	21
22	Various		1993		18,422		Various			18,422	22
23	Various		1994		2,170		Various			2,170	23
24	Various		1995		35,562		Various			35,562	24
25	Various		1996		3,400		Various			3,400	25
26	Various		1998		6,993		Various			6,993	26
27	Various		2000		898,348	22,015	Various	22,015		464,068	27
28	Various		2001		47,818		Various			47,818	28
29	Various		2002		14,534		Various			14,482	29
30	Various		2003		58,491		Various			58,491	30
31	Various		2004		2,564		Various			2,564	31
32	Various		2005		15,935		Various			15,935	32
33	Various		2006		21,876	1,023	Various	1,023		20,901	33
34	Various		2007		6,145		Various			6,095	34
35	Various		2008		111,502		Various			110,588	35
36	Various		2009		258,283	5,725	Various	5,725		205,801	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2010	\$ 40,492	\$ 2,850	Various	\$ 2,850	\$	\$ 40,076	37
38	Various	2011	8,859	886	Various	886		8,086	38
39	Various	2012	3,086,733	241,500	Various	241,500		1,938,727	39
40	Boiler Circulation Pump	2013	3,100	310	10	310		2,299	40
41	Sewer Discovery	2013	17,068	683	25	683		5,063	41
42	Excavate and Repair Sewer Lines/Manhole	2013	12,100	605	20	605		4,285	42
43	Vinyl for 400 Hall Lounge	2013	4,225	423	10	423		2,993	43
44	SNF 400 Hall/Alz Unit	2013	282,150	28,215	10	28,215		201,292	44
45	Sprinkler	2013	4,262	170	25	170		1,207	45
46	Nurse's Station Maglock Doors	2013	3,536	354	10	354		2,505	46
47	Directional Sign & Graphics	2013	3,730	373	10	373		2,518	47
48	Oxygen Room- Exhaust Fan & Roof Curb	2013	3,451	345	10	345		2,272	48
49	Sewer Project	2014	189,600	7,584	25	7,584		48,032	49
50	Repalce AC in the kitchen	2014	17,980	1,798	10	1,798		10,938	50
51	Asphalt paving & concrete of parking lot	2014	77,561	9,695	8	9,695		58,979	51
52	Whirlpool door	2014	2,805	280	10	280		1,566	52
53	Hydraulic sink install @ beauty shop	2015	3,564	356	10	356		1,901	53
54	Emergency Exit bar	2015	2,123	212	10	212		1,115	54
55	Install Emergency door	2015	9,993	999	10	999		5,246	55
56	Replace resident garage door	2015	522	52	10	52		270	56
57	Sump Pump	2015	562	56	10	56		277	57
58	New Rubber roof 40x30 section	2015	5,900	590	10	590		2,803	58
59	New Service hall double doors	2015	4,287	429	10	429		2,037	59
60	Install new roof Building 7	2015	10,875	1,088	10	1,088		5,166	60
61	Replace Mixing valve @ Memory care	2016	2,624	262	10	262		1,159	61
62	Therapy Room West Door	2016	4,049	405	10	405		1,788	62
63	400 Wing Trane AC unit	2016	6,875	688	10	688		2,865	63
64	200 Wing Heil 3 ton AC condensing unit	2016	2,681	268	10	268		1,117	64
65	200 Wing Heil 4 ton 3 phase AC unit	2016	4,284	428	10	428		1,785	65
66	Privacy Fence project at TCV	2016	84,965	4,248	20	4,248		16,993	66
67	Brick Memorial Walkway	2016	4,067	203	20	203		813	67
68	5 Ton HVAC unit	2016	2,340	234	10	234		936	68
69	STS SNF Landscaping	2016	12,104	605	20	605		2,320	69
70	TOTAL (lines 4 thru 69)		\$ 12,200,851	\$ 476,654		\$ 476,654	\$	\$ 5,678,324	70

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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,200,851	\$ 476,654		\$ 476,654	\$	\$ 5,678,324	1
2	500 Hall Egress exit doors delay	2016	3,402	340	10	340		1,276	2
3	North West Kitchen Door	2017	2,744	274	10	274		915	3
4	North East Kitchen Door	2017	2,744	274	10	274		915	4
5	Install Water filtration system	2017	1,695	169	10	169		551	5
6	Door Latching Bolts	2017	1,225	123	10	123		398	6
7	Otis Passenger Elevator	2017	107,676	5,384	20	5,384		17,497	7
8	Memory Care Unit 2' Wood Blinds	2017	1,918	192	10	192		623	8
9	GP Rhab Court Yard & Parking lot concret	2017	9,428	471	20	471		1,532	9
10	SNF Unit 205 Rubber Roof	2017	4,889	489	10	489		1,548	10
11	Gravel Parking lot near Maint. garage	2017	11,330	567	20	567		1,794	11
12	Memory Care Roof Build 200 & 400	2017	28,855	2,886	10	2,886		9,137	12
13	Memory Care Unit New Flooring	2017	45,234	4,523	10	4,523		13,947	13
14	Memory Care Nurse Sta. Counter	2017	2,194	219	10	219		677	14
15	Main Dining Solar Shades & Valances	2017	8,308	1,662	5	1,662		4,985	15
16	Memory Care Roof 200	2017	46,700	4,670	10	4,670		14,010	16
17	Memory Care Unit Wood Blinds (18)	2017	2,799	400	7	400		1,200	17
18	Memory Care Unit Doors (3)	2017	545	78	7	78		227	18
19	Replace Maple Trees (6)	2017	2,473	124	20	124		340	19
20	New Flooring in common room area	2017	7,817	782	10	782		2,085	20
21	Fire Sprinkler System upgrade piping	2017	5,690	813	7	813		2,100	21
22	Gas Water Heater 100gl	2017	5,725	573	10	573		1,479	22
23	Refinish SNF Residents Doors	2018	11,263	1,126	10	1,126		2,628	23
24	Dining Rooms 100 & 200 Hall doors Paint	2018	2,789	558	5	558		1,116	24
25	Chaple Tiffany style window panals	2018	1,439	288	5	288		575	25
26	Life Safety circuits panel	2018	12,685	2,537	5	2,537		5,074	26
27	3 Ton Goodman Heat Pump	2018	6,380	638	10	638		1,276	27
28	3 Ton Goodman Heat Pump	2018	6,380	638	10	638		1,276	28
29	3 Ton Goodman Heat Pump	2018	6,381	638	10	638		1,276	29
30	Sealcoat parking lot 13,300 sq ft	2018	9,975	499	20	499		914	30
31	100 Hall Hollow Metal Door	2018	1,859	186	10	186		310	31
32	Main Backflow	2018	4,147	829	5	829		1,382	32
33	Chapel Flooring	2018	2,724	272	10	272		431	33
34	TOTAL (lines 1 thru 33)		\$ 12,570,263	\$ 509,875		\$ 509,875	\$	\$ 5,771,818	34

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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,570,263	\$ 509,875		\$ 509,875	\$	\$ 5,771,818	1
2	Fire Alarm Panel	2019	1,226	245	5	245		327	2
3	Twined Furnaces MDS & Activities	2019	13,726	1,373	10	1,373		1,716	3
4	Sidewalk Replace off 300 Hall	2019	995	50	20	50		62	4
5	Water Heater Cong Build	2019	4,650	465	10	465		581	5
6	Maintenance Shop Elec Panel	2019	8,936	894	10	894		894	6
7	Courtyard Soffitt	2019	4,500	375	10	375		375	7
8	Courtyard handicap door install	2019	3,671	275	10	275		275	8
9	Admin Office Flooring	2019	4,253	284	10	284		284	9
10	Drywall in 300 Dining Room	2019	1,160	135	5	135		135	10
11	Replace Courtyard concrete	2020	9,800	245	20	245		245	11
12	Dining Room Flooring	2020	12,456	623	10	623		623	12
13	Trailir Park Concrete Replace /refurb	2020	16,289	271	20	271		271	13
14	Gazebo Shingles Replace	2020	2,497	62	10	62		62	14
15									15
16	Rounding			1		1		2	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)		\$ 12,654,421	\$ 515,173		\$ 515,173	\$	\$ 5,777,670	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	\$1,397,791	\$139,050	\$139,050	\$		\$1,121,707	71
72	Current Year Purchases	205,475	25,125	25,125			25,125	72
73	Fully Depreciated Assets	501,418	5,674	5,674			501,418	73
74	Home Office Allocation	363,391	53,610	53,610			199,705	74
75	TOTALS	\$2,468,075	\$223,459	\$223,459	\$		\$1,847,955	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Patient Transportation	2009 Tomberlin E4 Golf Cart	2009	\$8,850	\$	\$	\$	4	\$8,850
77	Patient Transportation	2009 Ford Starcraft bus	2009	48,290				8	47,795
78	Patient Transportation	2011 Dodge Grand Caravan Expi	2011	41,548				4	41,548
79	Home Office Allocation			11,317	900	900			10,316
80	TOTALS			\$110,005	\$900	\$900	\$		\$108,509

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	15,326,033
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	739,532
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	739,532
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	7,734,134

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	Tandem Axel Utility Trailer	\$900	\$	\$900
87	Land	405,769		
88	Garden Villa	1,427,720	48,260	194,690
89	Apartment/Congregate/Duplex	5,179,264	193,957	3,953,897
90				
91	TOTALS	\$7,013,653	\$242,217	\$4,149,487

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$9,018
93	Home Office Allocation	153,545
94		
95		\$162,563

* 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 X
16. Rental Amount for movable equipment: \$ 15,810 Description: copier and mail machine
(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

TCV ONLY HIRES CERTIFIED CNAs

B. EXPENSES

C. CONTRACTUAL INCOME

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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-3	hrs	\$	6,386	\$ 307,846	\$	6,386	\$ 307,846	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,262	94,667		1,262	94,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,970	362,274		6,970	362,274	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				230,305		230,305	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						13,593		13,593	12
13	Other (specify): Radiology						12,042		12,042	13
14	TOTAL			\$	14,618	\$ 764,787	\$ 255,940	14,618	\$ 1,020,727	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,626	\$	1
2	Cash-Patient Deposits	51,821		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 525,434)	692,880		3
4	Supply Inventory (priced at)	7,910		4
5	Short-Term Investments	4,110,125		5
6	Prepaid Insurance	1,618		6
7	Other Prepaid Expenses	43,246		7
8	Accounts Receivable (owners or related parties)	5,431,607		8
9	Other(specify): <u>Acc Int Rec/Other AR</u>	64,958		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,411,791	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	489,735		13
14	Buildings, at Historical Cost	18,217,522		14
15	Leasehold Improvements, at Historical Cost	867,362		15
16	Equipment, at Historical Cost	2,255,034		16
17	Accumulated Depreciation (book methods)	(11,601,782)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	267,349		21
22	Other Long-Term Assets (spe CIP	9,018		22
23	Other(specify): <u>Def Fin Costs</u>	68,636		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,572,874	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,984,665	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,821		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	446,190		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,500		32
33	Accrued Interest Payable	52,326		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 552,837	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,622,162		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deffered Entrance Fees</u>	408,565		43
44	<u>Other Liabilities</u>	896,049		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,926,776	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,479,613	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,505,052	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 20,984,665	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,204,713	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,204,713	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(699,669)	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) Rounding	8	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (699,661)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,505,052	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/19

Ending:

6/30/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,200,621	1
2	Discounts and Allowances for all Levels	(5,174,064)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,026,557	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,219,065	6
7	Oxygen	1,723	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,220,788	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	8,580	13
14	Non-Patient Meals	1,059	14
15	Telephone, Television and Radio	9,150	15
16	Rental of Facility Space	411	16
17	Sale of Drugs	399,668	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,152	19
20	Radiology and X-Ray	23,111	20
21	Other Medical Services	188,494	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 657,625	23
	D. Non-Operating Revenue		
24	Contributions	757,934	24
25	Interest and Other Investment Income***	105,924	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 863,858	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/Apt/Duplex</u>	1,439,558	28
28a	<u>Miscellaneous</u>	11,664	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,451,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,220,050	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,232,947	31
32	Health Care	4,865,948	32
33	General Administration	2,856,803	33
	B. Capital Expense		
34	Ownership	885,344	34
	C. Ancillary Expense		
35	Special Cost Centers	1,788,210	35
36	Provider Participation Fee	290,467	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,919,719	40
41	Income before Income Taxes (line 30 minus line 40)**	(699,669)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (699,669)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,017,089	44
45	Private Pay - Net Inpatient Revenue	(138,452)	45
46	Medicare - Net Inpatient Revenue	53,291	46
47	Other-(specify) <u>HMO, Med Adv, Med B</u>	94,629	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,026,557	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	2,064	2,120	\$ 98,095	\$ 46.27	1
2	Assistant Director of Nursing	1,338	1,442	45,443	31.51	2
3	Registered Nurses	15,990	16,330	355,888	21.79	3
4	Licensed Practical Nurses	41,897	44,507	870,803	19.57	4
5	CNAs & Orderlies	116,995	124,411	1,900,113	15.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,457	2,665	27,602	10.36	9
10	Activity Assistants	7,184	7,850	71,179	9.07	10
11	Social Service Workers	13,347	14,478	251,010	17.34	11
12	Dietician					12
13	Food Service Supervisor	903	1,138	31,757	27.91	13
14	Head Cook	4,305	4,833	61,571	12.74	14
15	Cook Helpers/Assistants	18,168	19,150	183,647	9.59	15
16	Dishwashers					16
17	Maintenance Workers	4,554	5,050	65,871	13.04	17
18	Housekeepers	20,016	21,338	187,290	8.78	18
19	Laundry	2,684	2,992	25,058	8.38	19
20	Administrator	2,008	2,279	132,209	58.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	624	640	16,559	25.87	23
24	Clerical	8,048	8,659	213,013	24.60	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	2,120	2,419	29,250	12.09	31
32	Other Health C: Marketing	4,490	5,075	126,005	24.83	32
33	Other(specify) AL/Apt/Duplex	35,497	37,532	470,287	12.53	33
34	TOTAL (lines 1 - 33)	304,689	324,908	\$ 5,162,650 *	\$ 15.89	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	338	\$ 18,173	V01-3	35
36	Medical Director	12	31,200	V09-3	36
37	Medical Records Consultant	24	2,400	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	11,070	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	3,153	V11-3	44
45	Social Service Consultant	53	3,153	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	644	\$ 69,149		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	3,221	226,399	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,221	\$ 226,399		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	
Steve Territo	Administrator	0	\$ 36,087	Workers' Compensation Insurance		\$ 82,746	IDPH License Fee	\$	
Andie Halley	Administrator	0	59,199	Unemployment Compensation Insurance		1,108	Advertising: Employee Recruitment		
Mike Robuka	Administrator	0	36,923	FICA Taxes		375,176	Health Care Worker Background Check		
				Employee Health Insurance		396,864	(Indicate # of checks performed)		
				Employee Meals			Patient Background Checks	177 1,770	
				Illinois Municipal Retirement Fund (IMRF)*					
				457 Plan Expense		3,343	License	2,263	
				Employee Expense		16,389	Dues	16,445	
				Employee Uniforms		4,387	Subscriptions	8,065	
				New Hire Expense		11,476	Home Office Allocation	4,763	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 970,674	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 33,306
(List each licensed administrator separately.)			\$ 132,209	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
B. Administrative - Other				Description	Line #	Amount	Description	Amount	
Management Fee			\$ 561,368				Out-of-State Travel	\$ 2,667	
							within allowable distance		
							In-State Travel	932	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 561,368				Seminar Expense	673	
(Attach a copy of any management service agreement)							Home Office Allocation	17,789	
C. Professional Services							Entertainment Expense	()	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
National Research	Employee Surveys		\$ 1,779				TOTAL	\$ 22,061	
Delaney, Delaney & Voorn	Legal		79,715						
Davis & Campbell	Legal		16,503						
Polsinelli Shughart	Legal		956						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(For legal fee disclosure, see page 39 of instructions)			\$ 98,953						

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount. LEADING AGE- \$11,098

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

5 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 18,110

Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 290,467

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

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

YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 1,059

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

YES

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

PLANTE MORAN PLLC

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

YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

YES

Attach invoices and a summary of services for all architect and appraisal fees.

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