

		FOR BHF USE					

LL1

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: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Rd Glen Carbon 62034
Number City Zip Code

County: Madison

Telephone Number: (618) 288-5014 Fax # (618) 288-0206

HFS ID Number:

Date of Initial License for Current Owners: 5/14/1979

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c)(3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller Telephone Number: (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Cindy A. Tefteller Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 E. Center Drive Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center

0023382 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</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>128</u>	TOTALS	<u>128</u>	<u>46,848</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>9,094</u>	<u>10,337</u>	<u>3,491</u>	<u>22,922</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>9,094</u>	<u>10,337</u>	<u>3,491</u>	<u>22,922</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.93%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) _____

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 5/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 5/14/1979 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 128 and days of care provided 2,472

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary		3,435	600,247	603,682		603,682	(8,357)	595,325			1
2	Food Purchase											2
3	Housekeeping	147,138	18,564		165,702		165,702		165,702			3
4	Laundry	63,059	2,531		65,590		65,590		65,590			4
5	Heat and Other Utilities			251,132	251,132		251,132		251,132			5
6	Maintenance	206,250	168	115,183	321,601		321,601	(9,921)	311,680			6
7	Other (specify):*											7
8	TOTAL General Services	416,447	24,698	966,562	1,407,707		1,407,707	(18,278)	1,389,429			8
	B. Health Care and Programs											
9	Medical Director			38,400	38,400		38,400		38,400			9
10	Nursing and Medical Records	2,170,964	154,158	68,785	2,393,907		2,393,907		2,393,907			10
10a	Therapy		580		580		580		580			10a
11	Activities	48,452	655	1,301	50,408		50,408		50,408			11
12	Social Services	47,357	8	631	47,996		47,996		47,996			12
13	CNA Training											13
14	Program Transportation		522	132	654		654		654			14
15	Other (specify):*	8,194			8,194		8,194	(8,194)				15
16	TOTAL Health Care and Programs	2,274,967	155,923	109,249	2,540,139		2,540,139	(8,194)	2,531,945			16
	C. General Administration											
17	Administrative	76,319		22,195	98,514		98,514	(5,698)	92,816			17
18	Directors Fees											18
19	Professional Services			38,966	38,966		38,966		38,966			19
20	Dues, Fees, Subscriptions & Promotions			25,545	25,545		25,545	(6,260)	19,285			20
21	Clerical & General Office Expenses	161,543	7,183	126,775	295,501		295,501		295,501			21
22	Employee Benefits & Payroll Taxes			483,144	483,144		483,144		483,144			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			144,019	144,019		144,019		144,019			26
27	Other (specify):*											27
28	TOTAL General Administration	237,862	7,183	840,644	1,085,689		1,085,689	(11,958)	1,073,731			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,929,276	187,804	1,916,455	5,033,535		5,033,535	(38,430)	4,995,105			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			183,997	183,997	(9,187)	174,810		174,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,702	12,702		12,702	(2,954)	9,748			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			196,699	196,699	(9,187)	187,512	(2,954)	184,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,669	280,191	349,860		349,860		349,860			39
40	Barber and Beauty Shops	3,200	217		3,417		3,417		3,417			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,449	194,449		194,449		194,449			42
43	Other (specify):* AL/Rtrmnt Ctr	1,043,280	26,487	3,705,680	4,775,447	9,187	4,784,634		4,784,634			43
44	TOTAL Special Cost Centers	1,046,480	96,373	4,180,320	5,323,173	9,187	5,332,360		5,332,360			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,975,756	284,177	6,293,474	10,553,407		10,553,407	(41,384)	10,512,023			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(8,194)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,357)	1		4
5	Telephone, TV & Radio in Resident Rooms	(9,921)	6		5
6	Rented Facility Space				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	(2,954)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,698)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,260)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,384)		\$	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))	\$ (41,384)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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	(8,357)	0	0	0	0	0	0	0	0	0	0	(8,357)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(9,921)	0	0	0	0	0	0	0	0	0	0	(9,921)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,278)	0	0	0	0	0	0	0	0	0	0	(18,278)	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):*	(8,194)	0	0	0	0	0	0	0	0	0	0	(8,194)	15
16	TOTAL Health Care and Programs	(8,194)	0	0	0	0	0	0	0	0	0	0	(8,194)	16
	C. General Administration													
17	Administrative	(5,698)	0	0	0	0	0	0	0	0	0	0	(5,698)	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	(6,260)	0	0	0	0	0	0	0	0	0	0	(6,260)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,958)	0	0	0	0	0	0	0	0	0	0	(11,958)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,430)	0	0	0	0	0	0	0	0	0	0	(38,430)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,384)	0	0	0	0	0	0	0	0	0	0	(41,384)	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
Don Sullivan	BOD					
Jamie Henderson	BOD					
Barry Wilson	BOD					
Ted Ellerman	BOD					
Eric Alvarez	BOD					
Charlotte Frisbie	BOD					
Pam Heepke	BOD					

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

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

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			\$			\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Eden Village Care Center

0023382

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	Cale Henke	BOD						1
2	Dan Highlander	BOD						2
3	Rick Neuhaus	BOD						3
4	John Roberts	BOD						4
5	Dean Schueler	BOD						5
6	Nancy Vetter-Staton	BOD						6
7	Michelle Weber	BOD						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	\$ 22,390,000	\$	2/1/2036	5.00-5.85	\$ 985,951	1
2	FCB Banks		X	Refinance Revenue Bonds	\$96,883.00	12/30/2020	16,125,000	16,125,000	12/30/2027	3.9000		2
3												3
4												4
5												5
	Working Capital											
6	The Bank of Edwardsville		X	Operations Line of Credit		8/11/2008	1,050,000				12,702	6
7												7
8												8
9	TOTAL Facility Related				\$96,883.00		\$ 39,565,000	\$ 16,125,000			\$ 998,653	9
	B. Non-Facility Related*											
10	Series 2006 Revenue Bonds			AL/Retirement Center							(985,951)	10
11	Interest Income Offset										(2,954)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (988,905)	14
15	TOTALS (line 9+line14)						\$ 39,565,000	\$ 16,125,000			\$ 9,748	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.) SEE ACCOUNTANTS' PREPARATION REPORT

** 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	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	338,490	8	
		2016	345,200	9	
		2017	380,322	10	
		2018	385,269	11	
		2019	391,573	12	
Real Estate Taxes are for the Assisted Living and Independent Living facilities and are reported on Line 43 in the current year.					
				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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT Sara McMahan

TELEPHONE 618-288-5014 FAX #: 618-288-0206

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.	<u>14-2-15-26-02-202-096</u>	<u>Cottonwood Trace PT Lot 3</u>	\$ <u>128.68</u>	\$ <u> </u>
2.	<u>14-1-15-26-02-202-098.001</u>	<u>NE/C NE</u>	\$ <u>73.08</u>	\$ <u> </u>
3.	<u>14-2-15-26-02-202-101</u>	<u>Cottonwood Trace - First Add LT PT</u>	\$ <u>1,605.76</u>	\$ <u> </u>
4.	<u>14-2-15-26-02-202-097</u>	<u>Cottonwood Trace PT Lot 2</u>	\$ <u>11,490.60</u>	\$ <u> </u>
5.	<u>14-2-15-26-02-202-165</u>	<u>Eden Village Subd 1st Addn Lot 1</u>	\$ <u>73,252.96</u>	\$ <u> </u>
6.	<u>14-2-15-26-02-202-100</u>	<u>Cottonwood Trace First Add PT Lots</u>	\$ <u>305,021.60</u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>391,572.68</u></u>	\$ <u><u> </u></u>

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,924

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).
Eden Retirement Center, Independent Living Facility (82 apartments; 40 duplex units)
Eden Retirement Center, Assisted Living (74 units)

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	Land - SNF		1979	\$ 166,295	1
2					2
3	TOTALS			\$ 166,295	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	128		1979	1979	\$ 2,008,520	\$	30	\$	\$	2,008,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Fixed Assets			1979	63,646		Various			63,646	9
10	1985 Fixed Assets			1985	28,768		Various			28,768	10
11	1989 Fixed Assets			1989	21,453		Various			21,453	11
12	1990 Fixes Assets			1990	34,575	770	Various	770		34,575	12
13	1991 Fixed Assets			1991	20,835		Various			20,835	13
14	1992 Fixed Assets			1992	106,730		Various			106,730	14
15	1993 Fixed Assets			1993	68,267		Various			68,267	15
16	1994 Fixed Assets			1994	42,035		Various			42,035	16
17	1995 Fixed Assets			1995	90,923		Various			90,923	17
18	1996 Fixed Assets			1996	64,116		Various			64,116	18
19	1997 Fixed Assets			1997	6,000		Various			6,000	19
20	1998 Fixed Assets			1998	1,632,945	39,650	Various	39,650		999,599	20
21	1999 Fixed Assets			1999	620,363	12,650	Various	12,650		387,633	21
22	2000 Fixed Assets			2000	31,137	451	Various	451		25,844	22
23	2001 Fixed Assets			2001	59,749		Various			59,749	23
24	2002 Fixed Assets			2002	9,200	368	Various	368		6,666	24
25	2003 Fixed Assets			2003	9,961	259	Various	259		8,583	25
26	2004 Fixed Assets			2004	23,265	959	Various	959		16,816	26
27	2005 Fixed Assets			2005	178,706	1,151	Various	1,151		167,867	27
28	2006 Fixed Assets			2006	119,533	4,146	Various	4,146		97,419	28
29	2007 Fixed Assets			2007	90,478		Various			90,478	29
30	2008 Fixed Assets			2008	47,724	360	Various	360		44,926	30
31	2010 Fixed Assets			2010	2,349		3			2,349	31
32	2011 Fixed Assets			2011	34,912	2,730	Various	2,730		33,616	32
33	2012 Fixed Assets			2012	151,427	6,000	Various	6,000		39,328	33
34	2013 Fixed Assets			2013	236,391	9,234	Various	9,234		109,097	34
35	Wander Guard			2015	12,000	800	20	800		4,333	35
36	Wander Guard			2015	11,880	1,004	10	1,004		4,385	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	Roof	2015	\$ 21,667	\$ 1,083	20	\$ 1,083	\$	\$ 5,777	37
38	Roof	2015	21,667	1,083	20	1,083		5,687	38
39	Roof	2015	21,667	1,083	20	1,083		5,687	39
40	Wander Guard	2015	4,605	461	10	461		2,417	40
41	Roof	2015	1,900	95	20	95		483	41
42	Wander Guard	2015	4,089	113	10	113		3,288	42
43	Condensing Unit	2016	4,489	449	10	449		2,170	43
44	Wander Guard	2016	7,791	779	10	779		3,635	44
45	Wander Guard	2016	4,089	409	10	409		2,011	45
46	FIN 47 Asset		20,377		12			20,377	46
47	Flooring - DON Office	2019	1,191	238	5	238		457	47
48	Flooring - Kitchen & Purchasing Offices	2019	2,457	491	5	491		860	48
49	Flooring - Administrator/Marketing offices and reception area	2019	2,988	598	5	598		996	49
50	Hardwood Flooring - Therapy Hallway and CFO Office	2019	4,162	832	10	832		1,249	50
51	Concrete - Parking Lots, Sidewalk and Curbing	2019	51,700	5,170	20	5,170		6,463	51
52	Roof	2020	8,600	4,300	2	4,300		4,300	52
53	CAT5e Cable	2020	2,560	384	5	384		384	53
54	Water Heater, Waterline - Therapy Room	2020	7,369	237	10	237		237	54
55	AC Unit, Fan Vent - Kitchen	2020	3,050	74	5	74		74	55
56	Sprinkler System Air Compressor, Pump - Therapy Room	2020	5,856	292	5	292		292	56
57	Flooring - Social Services and Admissions Office	2020	1,523	52	5	52		52	57
58	Water Heater - Care Center	2020	9,440	1,039	10	1,039		1,039	58
59	PTAC for 6 Care Center Rooms	2020	3,978	332	5	332		332	59
60	Furnace & Pump for Therapy Room	2020	6,956	211	5	211		211	60
61	Zultys Phone System	2020	120,111	11,010	10	11,010		11,010	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,172,170	\$ 111,347		\$ 111,347	\$	\$ 4,734,044	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$458,397	\$53,081	\$53,081	\$		\$287,927	71
72	Current Year Purchases	57,851	6,374	6,374			6,374	72
73	Fully Depreciated Assets	2,425,705					2,425,705	73
74								74
75	TOTALS	\$2,941,953	\$59,455	\$59,455	\$		\$2,720,006	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 Business	1990 Van - 275	1990	\$40,188	\$	\$	\$	10	\$40,188	76
77	Facility Business	2005 Ford 20 Passenger Van	2004	54,530				15	54,530	77
78	Facility Business	WheelChair Accessible Van	2007	45,800				10	45,800	78
79	Facility Business	2017 Dodge Van	2017	40,082	4,008	4,008		10	16,033	79
80	TOTALS			\$180,600	\$4,008	\$4,008	\$		\$156,551	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,461,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$174,810	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$174,810	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,610,601	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Retirement Center/Assisted Living/	\$	\$	\$	86
87	Apartments/Duplexes	27,311,104	669,242	12,871,198	87
88					88
89					89
90					90
91	TOTALS	\$27,311,104	\$669,242	\$12,871,198	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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: \$ Description:
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Pharmacy	39, 2					69,669		69,669	12
13	Other (specify): Therapy, Lab, X-Ray, Etc.					280,191			280,191	13
14	TOTAL			\$		\$ 280,191	\$ 69,669		\$ 349,860	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 2,336,678	\$	1
2	Cash-Patient Deposits	4,465		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 312,066)	79,376		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,108		6
7	Other Prepaid Expenses	33,357		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,543,984	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,890		13
14	Buildings, at Historical Cost	32,440,193		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,038,760		16
17	Accumulated Depreciation (book methods)	(20,481,799)		17
18	Deferred Charges	476,507		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Debt Service Reserves</u>	1,000,022		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,766,573	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,310,557	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 460,465	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,454		28
29	Short-Term Notes Payable	541,656		29
30	Accrued Salaries Payable	269,972		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,747		31
32	Accrued Real Estate Taxes(Sch.IX-B)	399,360		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Revenue</u>	857,365		36
37	<u>Other Accrued Expenses</u>	588,780		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,128,799	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,583,344		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	344,849		43
44	<u>Lease Deposits</u>	296,525		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,224,718	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,353,517	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 957,040	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 20,310,557	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 157,336	1
2	Restatements (describe):		2
3	2019 Audit Adjustments	19,100	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 176,436	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	780,604	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 780,604	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)	\$ 957,040	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 5,134,300	1
2	Discounts and Allowances for all Levels	(517,539)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,616,761	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,288	5
6	Therapy	616,284	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 617,572	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	4,316	13
14	Non-Patient Meals	8,357	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,559	21
22	Laundry	9,880	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,112	23
	D. Non-Operating Revenue		
24	Contributions	1,350	24
25	Interest and Other Investment Income***	4,271	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,621	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/Apt/Garden Home Revenue</u>	5,056,815	28
28a	<u>Other Revenue</u>	1,004,130	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,060,945	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,334,011	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,407,707	31
32	Health Care	2,540,139	32
33	General Administration	1,085,689	33
	B. Capital Expense		
34	Ownership	196,699	34
	C. Ancillary Expense		
35	Special Cost Centers	353,277	35
36	Provider Participation Fee	194,449	36
	D. Other Expenses (specify):		
37	<u>AL/IL Retirement Center</u>	4,775,447	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,553,407	40
41	Income before Income Taxes (line 30 minus line 40)**	780,604	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 780,604	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,436,120	44
45	Private Pay - Net Inpatient Revenue	2,006,300	45
46	Medicare - Net Inpatient Revenue	929,572	46
47	Other-(specify) <u>Managed Care</u>	244,769	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,616,761	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,960	2,072	\$ 71,743	\$ 34.63	1
2	Assistant Director of Nursing	1,977	2,070	66,148	31.96	2
3	Registered Nurses	5,640	6,027	169,959	28.20	3
4	Licensed Practical Nurses	31,588	35,270	911,929	25.86	4
5	CNAs & Orderlies	55,046	61,179	893,976	14.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,143	2,815	48,452	17.21	10
11	Social Service Workers	2,301	2,534	47,357	18.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	12,692	14,068	206,250	14.66	17
18	Housekeepers	11,336	12,930	147,138	11.38	18
19	Laundry	4,858	5,541	63,059	11.38	19
20	Administrator	1,090	1,310	76,319	58.26	20
21	Assistant Administrator					21
22	Other Administrative	7,954	8,779	161,543	18.40	22
23	Office Manager					23
24	Clerical					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	3,083	3,795	57,209	15.07	31
32	Other Health C: A/L R/C I/L	55,270	55,581	1,043,280	18.77	32
33	Other(specify) Sr N Mtn & Barbe	760	760	11,394	14.99	33
34	TOTAL (lines 1 - 33)	197,698	214,731	\$ 3,975,756 *	\$ 18.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		38,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		748	10, 3	39
40	Physical Therapy Consultant		8,020	10, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,168		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 14,045	10, 3	50
51	Licensed Practical Nurses		8,400	10, 3	51
52	Certified Nurse Assistants/Aides		25,939	10, 3	52
53	TOTAL (lines 50 - 52)		\$ 48,384		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Sara McMahan	Administrator	0	\$ 76,319
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,319
B. Administrative - Other			
Description			Amount
Interest Expense		\$	13,980
Bank Charges			1,001
Fines/Penalties/Miscellaneous			7,214
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 22,195
C. Professional Services			
Vendor/Payee	Type		Amount
Sandberg, Phoenix	Legal	\$	2,979
Mathis, Marifian & Richter	Legal		5,652
C.J. Schlosser & Company, LLC	Audits/Cost Reports		30,335
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 38,966
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	42,831
Unemployment Compensation Insurance			6,000
FICA Taxes			201,704
Employee Health Insurance			212,690
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			16,357
General Incentives			3,216
Vaccines			62
Uniforms			284
TOTAL (agree to Schedule V, line 22, col.8)			\$ 483,144
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			1,140
Health Care Worker Background Check (Indicate # of checks performed _____)			1,313
Patient Background Checks			1,250
Advertising/Marketing/Public Relations			6,260
Dues, Subscriptions, and Licenses			13,592
Less: Public Relations Expense		(	
Non-allowable advertising			(6,260)
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 19,285
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****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.

AAHSA & LSN

(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?

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

\$25,197

Line

10

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

Yes

If NO, attach a complete explanation.

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

No

If YES, give effective date of lease.

N/A

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

YES

X

NO

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

YES

NO

X

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

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

\$194,449

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

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

No

If YES, attach an explanation of the allocation.

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

Yes

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

No

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

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

\$None

Has any meal income been offset against related costs?

Yes

Indicate the amount. \$

8,357

(16) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

N/A

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

Yes

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

Yes

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:

C.J. Schlosser & Co., LLC

(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?

Yes

See page 39 of the instructions for details.

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

SEE ACCOUNTANTS' PREPARATION REPORT