

		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: 0012864

Facility Name: Pleasant View Luther Home

Address: 505 College Avenue Ottawa 61350
Number City Zip Code

County: Lasalle

Telephone Number: (815) 434-1130 Fax # (815) 434-1135

HFS ID Number:

Date of Initial License for Current Owners: 1/28/2013

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ 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: Tracy Mitchell Telephone Number: (317) 237-5500
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 07/01/2019 to 06/30/2020 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)	Dawn St. Clair-Davis	
	(Title)	Executive Director	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Tracy Mitchell Partner	
	(Firm Name & Address)	Bradley Associates 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225	
	(Telephone)	(317) 237-5500	Fax # (317) 237-5503
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Pleasant View Luther Home

0012864 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 N/A

	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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	5,911	16,928	5,992	28,831	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,911	16,928	5,992	28,831	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.77%

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) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 6/28/1937

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

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 90 and days of care provided 4,722

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	539,269	34,040	5,238	578,547	(206,542)	372,005		372,005			1
2	Food Purchase		412,318		412,318	(114,844)	297,474	(90,627)	206,847			2
3	Housekeeping	184,070	35,116	300	219,486	(7,901)	211,585		211,585			3
4	Laundry	23,980	11,922		35,902		35,902		35,902			4
5	Heat and Other Utilities			304,054	304,054		304,054		304,054			5
6	Maintenance	169,556	37,843	233,716	441,115		441,115	(10,902)	430,213			6
7	Other (specify):*											7
8	TOTAL General Services	916,875	531,239	543,308	1,991,422	(329,287)	1,662,135	(101,529)	1,560,606			8
	B. Health Care and Programs											
9	Medical Director			12,724	12,724		12,724		12,724			9
10	Nursing and Medical Records	2,557,484	168,265	10,060	2,735,809		2,735,809		2,735,809			10
10a	Therapy			659,938	659,938		659,938		659,938			10a
11	Activities	172,425	5,592	17,723	195,740		195,740		195,740			11
12	Social Services	93,732	779	27	94,538		94,538		94,538			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,823,641	174,636	700,472	3,698,749		3,698,749		3,698,749			16
	C. General Administration											
17	Administrative	156,900			156,900	(47,745)	109,155		109,155			17
18	Directors Fees											18
19	Professional Services			559,392	559,392	(46,500)	512,892	(406,582)	106,310			19
20	Dues, Fees, Subscriptions & Promotions			42,414	42,414	(12,907)	29,507		29,507			20
21	Clerical & General Office Expenses	188,217	43,708	430,841	662,766	(155,542)	507,224	(151,619)	355,605			21
22	Employee Benefits & Payroll Taxes			887,130	887,130	(135,111)	752,019		752,019			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,512	3,512	(1,044)	2,468	(81)	2,387			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			243,777	243,777	(74,181)	169,596		169,596			26
27	Other (specify):*											27
28	TOTAL General Administration	345,117	43,708	2,167,066	2,555,891	(473,030)	2,082,861	(558,282)	1,524,579			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,085,633	749,583	3,410,846	8,246,062	(802,317)	7,443,745	(659,811)	6,783,934			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			895,319	895,319		895,319		895,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,410,271	1,410,271		1,410,271	(63,010)	1,347,261			32
33	Real Estate Taxes			219,355	219,355		219,355	(135,725)	83,630			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,524,945	2,524,945		2,524,945	(198,735)	2,326,210			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,686	50,569	224,255		224,255		224,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,953	196,953		196,953		196,953			42
43	Other (specify):*	300,162	3,626	417,438	721,226	802,317	1,523,543	(1,523,543)				43
44	TOTAL Special Cost Centers	300,162	177,312	664,960	1,142,434	802,317	1,944,751	(1,523,543)	421,208			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,385,795	926,895	6,600,751	11,913,441		11,913,441	(2,382,089)	9,531,352			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	(74,262)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(10,902)	6		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	(63,010)	32		10
11	Discounts, Allowances, Rebates & Refunds	(16,365)	2		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				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	(146,469)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,664,499)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,975,507)		\$	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)	(406,582)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (406,582)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,382,089)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Luther Place and Estates/ Marketing	\$ (1,523,543)	43	1
2	Miscellaneous Income	(5,150)	21	2
3	Marketing Transportation	(81)	24	3
4	Non-Allowable Real Estate Taxes	(135,725)	33	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	(1,664,499)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(90,627)	0	0	0	0	0	0	0	0	0	0	(90,627)	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	(10,902)	0	0	0	0	0	0	0	0	0	0	(10,902)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(101,529)	0	0	0	0	0	0	0	0	0	0	(101,529)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(406,582)	0	0	0	0	0	0	0	0	0	(406,582)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(151,619)	0	0	0	0	0	0	0	0	0	0	(151,619)	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	(81)	0	0	0	0	0	0	0	0	0	0	(81)	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	(151,700)	(406,582)	0	0	0	0	0	0	0	0	0	(558,282)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(253,229)	(406,582)	0	0	0	0	0	0	0	0	0	(659,811)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(63,010)	0	0	0	0	0	0	0	0	0	0	(63,010)	32
33	Real Estate Taxes	(135,725)	0	0	0	0	0	0	0	0	0	0	(135,725)	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	(198,735)	0	0	0	0	0	0	0	0	0	0	(198,735)	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):*	(1,523,543)	0	0	0	0	0	0	0	0	0	0	(1,523,543)	43
44	TOTAL Special Cost Centers	(1,523,543)	0	0	0	0	0	0	0	0	0	0	(1,523,543)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,975,507)	(406,582)	0	0	0	0	0	0	0	0	0	(2,382,089)	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
Lutheran Life Ministries	100	Lutheran Home for the Aged	Arlington Heights, IL	Lutheran Life Ministri	Arlington Heights	Parent Holding Com
		Wittenberg Lutheran Village	Crown Point, IN	Lutheran Life Commu	Arlington Heights	Management Consul
		Arlington of Naples	Naples, FL	Lutheran Foundation f	Arlington Heights	Fundraising
		Luther Oaks	Bloomington, IL	Lutheran Community	Arlington Heights	Support Services

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

X YES

NO

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

1		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	19	Administrative Expense	\$ 406,582	Lutheran Life Communities	0.00%	\$	\$ (406,582)	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			\$ 406,582			\$	\$ * (406,582)	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	Sloan Bentley							1
2	Marie Carlson							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 Pleasant View Luther Home # 0012864 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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									\$		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.

Ending: 6/30/2020

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 2010 Bonds		X	Remodeling		9/23/10	\$ 16,695,000	\$	11/15/45	Varies	\$ 384,875	1	
2	Series 2012 Bonds		X	Addition to Assisted Living		11/2/12	6,410,000		5/15/42	6.0000	147,772	2	
3	Series 2019 Bonds		X	Refinance Debt/Capital Imp			31,944,474	31,835,172	2049	Varies	827,731	3	
4	Deferred Financing Costs		X								(10,074)	4	
5												5	
	Working Capital												
6	Mission Investment Fund		X	Borrowing		9/1/06	2,600,000		7/1/26	4.6250	59,938	6	
7	Capital Leases										29	7	
8												8	
9	TOTAL Facility Related						\$ 57,649,474	\$ 31,835,172			\$ 1,410,271	9	
	B. Non-Facility Related*												
10												10	
11	Investment Income										(63,010)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (63,010)	14	
15	TOTALS (line 9+line14)						\$ 57,649,474	\$ 31,835,172			\$ 1,347,261	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.)

** 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.			\$	114,031	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.)			\$	234,674	2
3. Under or (over) accrual (line 2 minus line 1).			\$	120,643	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	98,712	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.			\$	219,355	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	225,207	8	
		2016	235,782	9	
		2017	231,492	10	
		2018	234,355	11	
		2019	234,674	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 Pleasant View Luther Home COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0012864

CONTACT PERSON REGARDING THIS REPORT Dawn St. Clair-Davis

TELEPHONE (815) 434-1000 FAX #: (815) 434-1135

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. 22-14-416-016	1019 University Ave	\$ 4,560.48	\$
2. 22-14-401-019	505 College Ave	\$ 230,113.36	\$ 98,948.74
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 234,673.84	\$ 98,948.74

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: 125,137

B. General Construction Type: Exterior BrickFrame Brick-ConcreteNumber of Stories 4

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).

Pleasant View Luther Place - Duplexes for Independent Living - 20 units available

Pleasant View Luther Estates - Duplexes for Indepenent Living - 14 units available

Pleasant View Hearthstone - Apartments for Assited Living - 41 units available

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	SNF	522,750		\$ 339,943	1
2					2
3	TOTALS	522,750		\$ 339,943	3

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	90		1957	1957	\$ 170,416	\$		\$	\$	\$	4
5			1960	1960	64,957						5
6			1962	1962	767,743						6
7			1977	1977	3,768,795						7
8											8
	Improvement Type**										
9	1980 Building & Land Improvements			1980	8,096						9
10	1981 Building & Land Improvements			1981	95,606						10
11	1982 Building & Land Improvements			1982	109,621						11
12	1983 Building & Land Improvements			1983	52,137						12
13	1984 Building & Land Improvements			1984	51,282						13
14	1985 Building & Land Improvements			1985	68,023						14
15	1986 Building & Land Improvements			1986	12,076						15
16	1987 Building & Land Improvements			1987	82,723						16
17	1988 Building & Land Improvements			1988	7,182						17
18	1991 Building & Land Improvements			1991	12,726						18
19	1992 Building & Land Improvements			1992	41,495						19
20	1995 Building & Land Improvements			1995	21,584						20
21	1996 Building & Land Improvements			1996	196,509						21
22	1997 Building & Land Improvements			1997	37,277						22
23	2001 Building & Land Improvements			2001	47,645						23
24	2002 Building & Land Improvements			2002	1,370,163						24
25	2003 Building & Land Improvements			2003	6,130						25
26	2004 Building & Land Improvements			2004	5,098						26
27	2005 Building & Land Improvements			2005	1,350						27
28	2007 Building & Land Improvements			2007	176,083						28
29	2008 Building & Land Improvements			2008	23,938						29
30	2009 Building & Land Improvements			2009	30,277						30
31	2011 Building & Land Improvements			2011	15,506,066						31
32	2012 Building & Land Improvements			2012	564,357						32
33	Hoffman Development Fees Ph1 and Ph2			2013	51,157						33
34	Remote Fire Alarm Annunciator			2013	1,848						34
35	Roof HVAC Silencer			2013	41,926						35
36	Hearthstone 17 unit addition Ph4			2014	2,984,440						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 Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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

1	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 Village Square Building PH3	2014	\$ 5,220,883	\$		\$	\$	\$	37
38 Steps Voidfilled	2014	1,345						38
39 Bifold Doors	2015	3,660						39
40 Unit 101H Carpet	2015	3,348						40
41 Unit 103 Carpet	2015	2,107						41
42 Rood AC Unit	2016	4,761						42
43 Pipe Plumbing - Boiler Room	2016	3,862						43
44 Transistors in dining rooms	2016	681						44
45 Unit 207 Carpet and Flooring	2016	2,011						45
46 Sidewalk replacement	2016	14,875						46
47 Parking Lot Striping	2016	1,600						47
48 Sealcoat parking lot	2016	11,129						48
49 Christ Window and Scaffolding in Chapel	2017	17,529						49
50 Holby Mixing Valve	2017	8,202						50
51 Flooring - Unit 204	2017	2,159						51
52 Carpet - Unit 317	2017	1,372						52
53 Plumbing work for steam table replacement	2017	2,994						53
54 Sewer work 505 College	2018	2,803						54
55 Paint supplies to paint walls throughout main building	2018	1,398						55
56 Sewer Repair	2018	3,200						56
57 Parking Lot Repair	2018	4,649						57
58 Remove old floor and install new floor in 2nd floor bathroom	2018	980						58
59 Tiling and Drainage Repair	2018	8,760						59
60 Plumbing repair work to 908	2019	2,138						60
61 Flooring, steel door, heater, electical work for Villa 908	2019	9,310						61
62 Remove and replace kitchen cabinets and new lighting Villa 908	2019	4,997						62
63 HVAC repair	2019	21,760						63
64 Appliances	2019	3,259						64
65 Boiler - Replace pipes	2019	8,497						65
66 Air Conditioner	2019	2,485						66
67 Carper - Unit 212	2019	2,188						67
68 Condenser and Fan	2019	3,390						68
69 Non-Allowable	2019	(5,181)						69
70 TOTAL (lines 4 thru 69)		\$ 31,755,877	\$		\$	\$	\$	70

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

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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

1	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		\$ 31,755,877	\$		\$	\$	\$	1
2 Vinyl Flooring - resident room	2020	1,900						2
3 Recirculation pump and valve	2020	2,702						3
4 Furnace install PVLH Building	2020	5,250						4
5 Water main repair and backfill	2020	4,500						5
6 Carpeting for Hearthstone 116	2020	1,850						6
7 Carpeting for Hearthstone 208	2020	2,100						7
8 Garbage disposal motor - com	2020	1,565						8
9 Painting for Room 404	2020	750						9
10								10
11								11
12								12
13								13
14 Financial Statement Depreciation			704,009		704,009		11,667,974	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 31,776,494	\$ 704,009		\$ 704,009	\$	\$ 11,667,974	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,052,749	\$ 190,298	\$ 190,298	\$	Var	\$ 1,476,120	71
72	Current Year Purchases	33,982	1,012	1,012		Var	1,012	72
73	Fully Depreciated Assets	1,056,986				Var	1,056,986	73
74								74
75	TOTALS	\$ 3,143,717	\$ 191,310	\$ 191,310	\$		\$ 2,534,118	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			\$ 117,575	\$	\$	\$	Var	\$ 117,575	76
77										77
78										78
79										79
80	TOTALS			\$ 117,575	\$	\$	\$		\$ 117,575	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)	\$ 35,377,729	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 895,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 895,319	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)	\$ 14,319,667	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	Non-Allowable	\$ 3,685,793	\$ 133,153	\$ 3,294,974	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,685,793	\$ 133,153	\$ 3,294,974	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 90,091	92
93			93
94			94
95		\$ 90,091	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☒ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 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

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

Fiscal Year Ending	Annual Rent
12. /2021	\$
13. /2022	\$
14. /2023	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

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

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	

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	10a-3	hrs	\$	5,008	\$ 284,024	\$	5,008	\$ 284,024	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,536	52,607		1,536	52,607	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,849	323,307		5,849	323,307	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				173,686		173,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray	39-3				50,569			50,569	12
13	Other (specify):									13
14	TOTAL			\$	12,393	\$ 710,507	\$ 173,686	12,393	\$ 884,193	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,429,179	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 163,072)	859,803		3
4	Supply Inventory (priced at)	45,307		4
5	Short-Term Investments	25,084		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	294,114		7
8	Accounts Receivable (owners or related parties)	(372,236)		8
9	Other(specify): <u>Trustee Held Funds</u>	2,922,295		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,203,546	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	347,068		13
14	Buildings, at Historical Cost	35,046,222		14
15	Leasehold Improvements, at Historical Cost	136,276		15
16	Equipment, at Historical Cost	3,533,956		16
17	Accumulated Depreciation (book methods)	(17,614,641)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	185,138		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP / Bond Cost</u>	587,659		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,221,678	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 28,425,224	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,340	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	469,667		29
30	Accrued Salaries Payable	379,612		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,253		31
32	Accrued Real Estate Taxes(Sch.IX-B)	235,847		32
33	Accrued Interest Payable	236,374		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	398,162		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,989,255	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	31,365,504		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Resident Entrance Fees and Other</u>	4,099,729		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 35,465,233	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 37,454,488	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,029,264)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 28,425,224	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,157,144)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,157,144)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,232,120)	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) Transfer of Assets	(1,640,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,872,120)	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)	\$ (9,029,264)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant View Luther Home

0012864

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

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	\$ 10,800,585	1
2	Discounts and Allowances for all Levels	(2,067,616)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,732,969	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,264,681	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,264,681	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	1,952	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	74,262	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,902	16
17	Sale of Drugs	172,122	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,596	19
20	Radiology and X-Ray	11,949	20
21	Other Medical Services	93,369	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 398,152	23
	D. Non-Operating Revenue		
24	Contributions	33,865	24
25	Interest and Other Investment Income***	63,010	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 96,875	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue	(2,811,356)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (2,811,356)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,681,321	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,991,422	31
32	Health Care	3,698,749	32
33	General Administration	2,555,891	33
	B. Capital Expense		
34	Ownership	2,524,945	34
	C. Ancillary Expense		
35	Special Cost Centers	945,481	35
36	Provider Participation Fee	196,953	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,913,441	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,232,120)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,232,120)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 923,269	44
45	Private Pay - Net Inpatient Revenue	7,300,057	45
46	Medicare - Net Inpatient Revenue	547,783	46
47	Other-(specify) <u>HMO</u>	128,328	47
48	Other-(specify) <u>Other</u>	(166,468)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,732,969	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	2,564	2,784	\$ 124,841	\$ 44.84	1
2	Assistant Director of Nursing	1,713	1,758	60,093	34.18	2
3	Registered Nurses	21,558	22,971	763,215	33.23	3
4	Licensed Practical Nurses	9,190	9,790	263,097	26.87	4
5	CNAs & Orderlies	65,926	69,295	1,089,260	15.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,163	9,667	171,110	17.70	10
11	Social Service Workers	3,520	3,718	96,139	25.86	11
12	Dietician	1,162	1,162	20,144	17.34	12
13	Food Service Supervisor	7,781	8,320	183,129	22.01	13
14	Head Cook	7,766	8,489	127,466	15.02	14
15	Cook Helpers/Assistants	17,899	18,419	183,193	9.95	15
16	Dishwashers					16
17	Maintenance Workers	9,639	10,440	200,876	19.24	17
18	Housekeepers	16,294	17,699	193,775	10.95	18
19	Laundry	1,989	2,134	23,875	11.19	19
20	Administrator	1,852	1,974	158,803	80.45	20
21	Assistant Administrator					21
22	Other Administrative	8,470	8,932	157,383	17.62	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	1,705	1,975	32,643	16.53	31
32	Other Health C: AL/IL/Marketing	19,938	21,397	379,053	17.72	32
33	Other(specify) Nursing Admin	7,733	8,272	157,700	19.06	33
34	TOTAL (lines 1 - 33)	215,862	229,196	\$ 4,385,795 *	\$ 19.14	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		\$ 2,673	1-3	35
36	Medical Director	12 months	12,724	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		9,274	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		28,406	21-3	45
46	Other(specify) Life Enrichment		841	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 53,918		49

C. CONTRACT NURSES

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

Facility Name & ID Number

Pleasant View Luther Home

STATE OF ILLINOIS

0012864

Report Period Beginning:

07/01/2019

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn St. Clair-Davis	Executive Director	0	\$ 155,054
Becky Cattani	Executive Director	0	1,846
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 156,900

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Lutheran Life	Mgmt Fee	\$ 406,582
Bradley Associates	Accounting	28,342
CliftonLarsonAllen	Accounting	14,768
See Attached	Legal	109,700
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 559,392

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 114,764
Unemployment Compensation Insurance	19,104
FICA Taxes	251,402
Employee Health Insurance	331,740
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	22,620
Life Insurance	5,633
Benefit Offset	2,341
Employee Physicals	1,160
Other	3,255
TOTAL (agree to Schedule V, line 22, col.8)	\$ 752,019

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 10,280
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Illinois Aging Services	6,697
Leading Age	10,923
Dues & Memberships	7,820
Subscriptions & Publications	6,694
Non-Care Amount	(12,907)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	1,633
Seminar Expense	1,879
Non-Care Amount	(1,125)
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,387

* 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 - 10,923

(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? Varies

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

\$ 21,658 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.

\$ 196,953

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.

\$ N/A

Has any meal income been offset against related costs? Yes

Indicate the amount. \$ 74,262

(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?

100

d. Have vehicle usage logs been maintained?

Yes

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: CliftonLarsonAllen LLP

(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.

HFS 3745 (N-4-99)

IL478-2471