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: 0050682

Facility Name: Hickorypoint Christian Vill

Address: 565 West Marion Ave (Number) Forsyth (City) 62535 (Zip Code)

County: Macon

Telephone Number: 217.872.1122 **Fax #** 217.875.0600

HFS ID Number:

Date of Initial License for Current Owners: 9/22/2011

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314.587-7924
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 7/1/2019 to 6/30/2020 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) Chuck Schmitz
(Title) CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,424	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	64	TOTALS	64	23,424	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	427	8,569	12,667	21,663	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	427	8,569	12,667	21,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.48%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, lawn & maintenance care, housekeeping, laundry services for IL residents

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/15/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/15/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 10,564

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	243,109	10,154	22,290	275,553		275,553		275,553			1
2	Food Purchase		194,189		194,189		194,189	(14,174)	180,015			2
3	Housekeeping	93,001	30,021		123,022		123,022		123,022			3
4	Laundry	42,357			42,357		42,357		42,357			4
5	Heat and Other Utilities			41,107	41,107		41,107	(15,168)	25,939			5
6	Maintenance	94,022	8,493	48,131	150,646		150,646	233	150,879			6
7	Other (specify):* Trash			13,829	13,829		13,829		13,829			7
8	TOTAL General Services	472,489	242,857	125,357	840,703		840,703	(29,109)	811,594			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,544,630	163,639	281,777	2,990,046		2,990,046	(10,334)	2,979,712			10
10a	Therapy			1,343,432	1,343,432		1,343,432		1,343,432			10a
11	Activities	58,024	3,109	4,837	65,970		65,970		65,970			11
12	Social Services	142,196	44		142,240		142,240		142,240			12
13	CNA Training											13
14	Program Transportation			787	787		787	(587)	200			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,744,850	166,792	1,648,833	4,560,475		4,560,475	(10,921)	4,549,554			16
	C. General Administration											
17	Administrative	219,100		585,824	804,924		804,924	(472,003)	332,921			17
18	Directors Fees											18
19	Professional Services			3,517	3,517		3,517	92,251	95,768			19
20	Dues, Fees, Subscriptions & Promotions			29,644	29,644		29,644	4,297	33,941			20
21	Clerical & General Office Expenses	152,290	21,592	165,231	339,113		339,113	141,515	480,628			21
22	Employee Benefits & Payroll Taxes			690,372	690,372		690,372	79,362	769,734			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,166	4,166		4,166	17,819	21,985			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			163,187	163,187		163,187	37,302	200,489			26
27	Other (specify):* Marketing	87,483	2,574	22,083	112,140		112,140	(112,140)				27
28	TOTAL General Administration	458,873	24,166	1,664,024	2,147,063		2,147,063	(211,597)	1,935,466			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,676,212	433,815	3,438,214	7,548,241		7,548,241	(251,627)	7,296,614			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.

Facility Name & ID Number Hickorypoint Christian Vill #0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			545,885	545,885		545,885	59,286	605,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			355,364	355,364		355,364	(2,900)	352,464			32
33	Real Estate Taxes			228,797	228,797		228,797		228,797			33
34	Rent-Facility & Grounds			17,305	17,305		17,305		17,305			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Deferred Financing Costs			3,788	3,788		3,788		3,788			36
37	**TOTAL Ownership**			1,151,139	1,151,139		1,151,139	56,386	1,207,525			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			519,765	519,765		519,765	(24,030)	495,735			39
40	Barber and Beauty Shops			33,984	33,984		33,984		33,984			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,509	102,509		102,509		102,509			42
43	Other (specify):* Apt/Congregate	856,303		1,841,763	2,698,066		2,698,066	(2,698,066)				43
44	**TOTAL Special Cost Centers**	856,303		2,498,021	3,354,324		3,354,324	(2,722,096)	632,228			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,532,515	433,815	7,087,374	12,053,704		12,053,704	(2,917,337)	9,136,367			45

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,457)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,887)	5		5
6	Rented Facility Space	(2,821)	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	(2,900)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,334)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,897)	21		24
25	Fund Raising, Advertising and Promotional	(112,140)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg5A	(2,887,488)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,095,935)		$	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)	178,598	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 178,598		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,917,337)		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

Hickorypoint Christian Vill

ID# 0050682

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment/Congregate	$ (2,882,230)	43	1
2	Vending Revenue	(717)	02	2
3	Miscellaneous Revenue	(1,416)	21	3
4	Lobbying Expense	(477)	20	4
5	Transportation Revenue	(587)	14	5
6	Collections Fee	(2,061)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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35				35
36				36
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38				38
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,887,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,174)	0	0	0	0	0	0	0	0	0	0	(14,174)	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	(16,887)	1,719	0	0	0	0	0	0	0	0	0	(15,168)	5
6	Maintenance	(2,821)	3,054	0	0	0	0	0	0	0	0	0	233	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(33,882)	4,773	0	0	0	0	0	0	0	0	0	(29,109)	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	(10,334)	0	0	0	0	0	0	0	0	0	0	(10,334)	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	(587)	0	0	0	0	0	0	0	0	0	0	(587)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,921)	0	0	0	0	0	0	0	0	0	0	(10,921)	16
	C. General Administration													
17	Administrative	0	(472,003)	0	0	0	0	0	0	0	0	0	(472,003)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,061)	94,312	0	0	0	0	0	0	0	0	0	92,251	19
20	Fees, Subscriptions & Promotions	(477)	4,774	0	0	0	0	0	0	0	0	0	4,297	20
21	Clerical & General Office Expenses	(51,324)	192,839	0	0	0	0	0	0	0	0	0	141,515	21
22	Employee Benefits & Payroll Taxes	0	79,362	0	0	0	0	0	0	0	0	0	79,362	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,819	0	0	0	0	0	0	0	0	0	17,819	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	37,302	0	0	0	0	0	0	0	0	0	37,302	26
27	Other (specify):*	(112,140)	0	0	0	0	0	0	0	0	0	0	(112,140)	27
28	**TOTAL General Administration**	(166,002)	(45,595)	0	0	0	0	0	0	0	0	0	(211,597)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(210,805)	(40,822)	0	0	0	0	0	0	0	0	0	(251,627)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickorypoint Christian Vill **#** 0050682 **Report Period Beginning:** 7/1/2019 **Ending:** 6/30/2020

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	59,286	0	0	0	0	0	0	0	0	0	59,286	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	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**	(2,900)	59,286	0	0	0	0	0	0	0	0	0	56,386	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	(24,030)	0	0	0	0	0	0	0	0	0	(24,030)	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):*	(2,882,230)	184,164	0	0	0	0	0	0	0	0	0	(2,698,066)	43
44	**TOTAL Special Cost Centers**	(2,882,230)	160,134	0	0	0	0	0	0	0	0	0	(2,722,096)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,095,935)	178,598	0	0	0	0	0	0	0	0	0	(2,917,337)	45

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Midwest Christian Villages, Inc. d/b/a Christian Horizons	100.00%	$ 1,719	$ 1,719	1
2	V	6	Maintenance				3,054	3,054	2
3	V	17	Administrative	585,824			113,821	(472,003)	3
4	V	19	Professional Services				94,312	94,312	4
5	V	21	Clerical				138,688	138,688	5
6	V	22	Employee Benefits				79,362	79,362	6
7	V	20	Dues & Subscriptions				4,774	4,774	7
8	V	24	Travel and Seminars				17,819	17,819	8
9	V	26	Insurance				37,302	37,302	9
10	V	30	Depreciation				59,286	59,286	10
11	V	21	Other Administrative Expense				54,151	54,151	11
12	V	43	Apt/Congregate/Wellness				184,164	184,164	12
13	V	39	Pharmacy Services	450,460	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	426,430	(24,030)	13
14	Total			$ 1,036,284			$ 1,214,882	$ * 178,598	14

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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29								29
30								30

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority		X	Refiance Debt		12/12/18	$ 8,002,461	$ 8,213,416	5/15/2040	0.0500	$ 99,792	1
2	Illinois Finance Authority		X	Refiance Debt - New Construction		7/1/10	5,500,000	3,215,535	5/15/2027	0.0625	190,167	2
3	Illinois Finance Authority		X	Refiance Debt		3/1/16	5,646,005	5,387,139	5/15/2040	0.0500	65,405	3
4												4
5												5
	Working Capital											
6	Interest Offset										(2,900)	6
7												7
8												8
9	TOTAL Facility Related						$ 19,148,466	$ 16,816,090			$ 352,464	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,148,466	$ 16,816,090			$ 352,464	15

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

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

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickorypoint Christian Vill COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0050682

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE 314-587-7924 FAX #: 214-732-8686

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-07-15-452-019	See Attachment	$ 8,412.56	$
2.	07-07-15-452-018	See Attachment	$ 5,246.14	$
3.	07-07-15-451-006	See Attachment	$ 306,080.27	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 319,738.97	$

B. **Real Estate Tax Cost Allocations**

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,327 B. General Construction Type: Exterior Siding/Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Apartments
Congregate

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 188,520	1
2	Home Office Allocation			9,589	2
3	TOTALS			$ 198,109	3

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		2011	2011	$ 6,531,557	$ 217,719		$ 217,719	$	$ 1,959,467	4
5			2011	2011	342,749	11,425		11,425		102,825	5
6	17		2014	2014	1,966,535	49,163		49,163		311,368	6
7											7
8	Home Office Allocation				126,038	3,473		3,473		71,978	8
	Improvement Type**										
9	Landscaping for HPCV GradingSeeding			2006	52,728	2,636	10	2,636		38,008	9
10	Irrigation system			2006	31,650	1,583	10	1,583		22,814	10
11	Land Improvement			2006	185,674	9,398	10	9,398		133,822	11
12	Landscaping front entrance flagpole			2006	14,200		10			14,084	12
13	Vinyl Fence Panels			2010	770	64	15	64		764	13
14	2010 Landscaping			2010	9,793	979	10	979		9,711	14
15	Ansul fire suppression system rebuild			2011	1,016	102	10	102		898	15
16	Slit Seed Landscaping			2011	3,350	335	10	335		3,071	16
17	Pavement sealing & crackfilling &marki			2011	4,850	1	10	1		4,800	17
18	Elopement Accutech IS Haven House Wing			2012	30,500	3,050	15	3,050		23,638	18
19	Electronic Locks for SNF			2012	7,599	760	10	760		5,763	19
20	Set up Door Alarm w Key Pad Entry (SNF			2012	1,538	154	10	154		1,230	20
21	Cabinets Upper & Base Laminate			2012	3,300	330	10	330		2,640	21
22	R&R Water Main from Laundry & Main Bld			2013	2,681	179	20	179		1,296	22
23	870 Hope R&R Carpet & Vinyl			2013	4,441	444	20	444		3,145	23
24	Nursing Narcotic Cabinet			2013	14,432	962	20	962		6,735	24
25	Signage			2013	16,828	1,683	10	1,683		11,359	25
26	Full wall panel for lobby			2013	2,124	212	10	212		1,434	26
27	Accent lighting near receptionist			2013	1,150	115	10	115		786	27
28	HH room 321 carpet heven			2013	771	77	10	77		507	28
29	Landscape Renovations			2013	31,150	3,115	10	3,115		21,026	29
30	Shrubs, Tress Landscape			2013	12,000	1,200	10	1,200		8,300	30
31	Retaining wall uility road trees			2013	4,630	463	10	463		3,125	31
32	New sidewalk & driveway			2013	4,650	233	10	233		1,608	32
33	Repave Marion Av front enterance way			2014	44,726	2,236	20	2,236		13,791	33
34	Pendant System (Lighting damage)			2014	16,440	1,644	10	1,644		9,590	34
35	Panelboard surge device			2015	59,400	5,940	10	5,940		32,670	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	Awning / Carport	2015	$ 3,995	$ 400	10	$ 400	$	$ 2,097	37
38	Landscaping project Rear foundation	2014	21,260	2,126	10	2,126		12,047	38
39	Asphalt paving @ Marion	2014	49,875	6,234	8	6,234		35,848	39
40	Concrete driveway & sidewalk	2015	7,282	728	10	728		3,823	40
41	Gate & Concrete dumpster area	2015	3,264	326	10	326		1,686	41
42	Raise sidewalk laundry building	2015	5,400	540	10	540		2,700	42
43	Garden Home Windows	2015	9,668	967	10	967		4,834	43
44	811 Hope Carpet and Paint	2015	4,549	455	10	455		2,275	44
45	Paint, Carpet, Toilets, Lights, Vents	2015	6,139	614	10	614		3,018	45
46	Resurface Raods	2015	68,900	6,890	10	6,890		33,876	46
47	Paint, Carpet, Appliances, Toilets	2015	11,994	1,199	10	1,199		5,897	47
48	AL Haven 325 Carpet Replacement	2015	742	74	10	74		365	48
49	931 Hope Carpet	2015	1,161	116	10	116		591	49
50	Paint, Ceiling Fan, Lights, 2 Toilets	2015	954	95	10	95		461	50
51	Custom Gable Main Entrance Canopy	2015	15,557	1,556	10	1,556		7,260	51
52	Install auto sprinkler system @ canopy	2015	1,648	165	10	165		769	52
53	Alarm LCD Annunciator panel	2016	2,899	290	10	290		1,305	53
54	Resident infinity wall guards SNF rooms	2016	16,061	1,606	10	1,606		7,094	54
55	(4) HVAC Econmizers	2016	6,125	613	10	613		2,552	55
56	Raise sidewalk / driveway @ 565 Marion	2016	1,900	190	10	190		776	56
57	Underground cable for cable TV	2016	4,554	455	10	455		1,860	57
58	Removed & replaced 17 trees	2016	5,280	528	10	528		2,156	58
59	Raised Driveways & Sidewalks	2017	3,250	325	10	325		1,056	59
60	Fabricate backsplash in Service Kitchens	2018	7,733	773	10	773		1,804	60
61	Trane HVAC Dining, Front & Rear Entrance	2018	16,249	1,625	10	1,625		2,573	61
62	Riser Room/ Attic Sprinkler Pipe	2018	1,999	200	10	200		333	62
63	Damper on 2 RTU Economizer	2018	3,342	334	10	334		613	63
64	Trane Coil SN 4GXCB002	2019	924	92	10	92		123	64
65	Mini Split AC unit Kitchenette	2019	2,950	295	10	295		393	65
66	Mini Split AC unit Kitchenette Haven	2019	2,500	250	10	250		333	66
67	Dietary Dark gray Flooring 1632sq ft	2019	22,032	2,203	10	2,203		3,305	67
68	HVAC Mini-Split 12,000BTU	2018	3,412	341	10	341		682	68
69	HVAC Mini-Split 24,000BTU	2018	5,312	531	10	531		1,062	69
70	TOTAL (lines 4 thru 69)		$ 9,848,180	$ 352,811		$ 352,811	$	$ 2,967,820	70

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	
1	Totals from Page 12A, Carried Forward		$ 9,848,180	$ 352,811		$ 352,811	$	$ 2,967,820	1
2	North Section Pavement Seal	2018	9,001	900	10	900		1,650	2
3	South Section Pavement Seal	2018	5,985	599	10	599		1,097	3
4	Trane Furnace/AC Unit	2019	3,437	344	10	344		372	4
5	Sprinkler Inspection	2019	1,692	169	10	169		197	5
6	Fire Sprinkler System Inspection	2020	7,646	64	10	64		64	6
7	Trane AC Unit (Up & Downstairs	2020	5,002	83	10	83		83	7
8	AC Ductwork/ Insulation	2019	3,000	333	6	333		333	8
9	Library Flooring/Reno	2019	7,188	539	10	539		539	9
10	Outdoor Vinyl Privacy Fence 48 & 96in	2020	4,484	224	10	224		224	10
11	Kitchen RTU Carrier Rooftop Units	2020	9,436	393	10	393		393	11
12	Clubhouse Landscape Grass Area	2020	325	11	10	11		11	12
13	HPCV Clubhouse New Const.	2020	255,516	12,776	10	12,776		12,776	13
14	HPCV Clubhouse	2020	2,915	729	2	729		729	14
15	Mini Split AC Unit IT Room	2020	3,372	84	10	84		84	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)		$ 10,167,178	$ 370,060		$ 370,060	$	$ 2,986,373	34

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

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,639,363	$ 139,276	$ 139,276	$		$ 1,246,221	71
72	Current Year Purchases	110,709	19,875	19,875			19,875	72
73	Fully Depreciated Assets	84,979	5,880	5,880			84,979	73
74	Home Office Allocation	364,201	53,730	53,730			200,149	74
75	TOTALS	$ 2,199,252	$ 218,761	$ 218,761	$		$ 1,551,224	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2014 Ford Starcraft Allstar E350		$ 55,637	$	$	$	4	$ 54,497	76
77	Snow Removal	Kubota L3560 Tractor w/bucket plow		37,909	5,416	5,416		7	18,052	77
78	Patient Transportation	2017 Dodge Grand Caravan		35,405	8,851	8,851		4	26,554	78
79	Home Office Allocation			11,342	902	902			10,339	79
80	TOTALS			$ 140,293	$ 15,169	$ 15,169	$		$ 109,442	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)	$ 12,704,832	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 603,990	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 603,990	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)	$ 4,647,039	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	A/L Building & Equipment	$ 8,036,892	$ 258,865	$ 3,607,321	86
87	Duplex Building/Equip/Land Imp	7,082,690	194,435	4,267,473	87
88	Land	668,388			88
89					89
90					90
91	TOTALS	$ 15,787,970	$ 453,300	$ 7,874,794	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 61,007	92
93	Home Office Allocation	153,887	93
94			94
95		$ 214,894	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.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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: ____ *

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	$

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: $ 17,305 Description: See Attachment
(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.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] NO

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

   HPCV Only Hires Certified CNAs

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	11,202	$ 595,682	$	11,202	$ 595,682	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,373	84,808		3,373	84,808	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		13,111	662,942		13,111	662,942	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				368,214		368,214	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						26,399		26,399	12
13	Other (specify): Radiology						40,057		40,057	13
14	TOTAL			$	27,686	$ 1,343,432	$ 434,670	27,686	$ 1,778,102	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.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2020 (last day of reporting year)

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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 122,250)	1,262,898		3
4	Supply Inventory (priced at)	7,363		4
5	Short-Term Investments	50,857		5
6	Prepaid Insurance	1,014		6
7	Other Prepaid Expenses	36,622		7
8	Accounts Receivable (owners or related parties)	4,381,910		8
9	Other(specify): Accrued Interest Receivable	140		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,740,804	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	856,908		13
14	Buildings, at Historical Cost	23,065,162		14
15	Leasehold Improvements, at Historical Cost	1,282,988		15
16	Equipment, at Historical Cost	2,776,574		16
17	Accumulated Depreciation (book methods)	(12,239,367)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,263,244		21
22	Other Long-Term Assets (spe CIP	61,007		22
23	Other(specify): Deferred Financing Costs	289,818		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,356,334	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,097,138	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,112		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	501,134		32
33	Accrued Interest Payable	665,433		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	43,610		36
37	Security Deposits Payable	263,903		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,776,192	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	16,816,090		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	1,837,128		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 18,653,218	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,429,410	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,667,728	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 23,097,138	$	48

***(See instructions.)**

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,906,535	1
2	Restatements (describe):		2
3	Temp Restricted Contribution Activity		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,906,535	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	761,264	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) Rounding	(71)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 761,193	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)**	$ 2,667,728	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,290,331	1
2	Discounts and Allowances for all Levels	(6,075,322)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (784,991)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,148,517	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,148,517	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	33,430	13
14	Non-Patient Meals	13,457	14
15	Telephone, Television and Radio	5,264	15
16	Rental of Facility Space	2,821	16
17	Sale of Drugs	700,860	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,038	19
20	Radiology and X-Ray	55,196	20
21	Other Medical Services	172,829	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,033,895	23
	D. Non-Operating Revenue		
24	Contributions	329,523	24
25	Interest and Other Investment Income***	2,900	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 332,423	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Duplex/Apt Revenue	3,057,075	28
28a	Miscellaneous Revenue	28,049	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,085,124	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,814,968	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	840,703	31
32	Health Care	4,560,475	32
33	General Administration	2,147,063	33
	B. Capital Expense		
34	Ownership	1,151,139	34
	C. Ancillary Expense		
35	Special Cost Centers	3,251,815	35
36	Provider Participation Fee	102,509	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,053,704	40
41	**Income before Income Taxes (line 30 minus line 40)****	761,264	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 761,264	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 55,884	44
45	Private Pay - Net Inpatient Revenue	2,746,122	45
46	Medicare - Net Inpatient Revenue	(2,026,161)	46
47	Other-(specify) HMO/HMO Anc, Med Advantage	(605,654)	47
48	Other-(specify) Nursing/Outpatiend Part B	(955,182)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ (784,991)	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.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,824	3,920	$ 153,948	$ 39.27	1
2	Assistant Director of Nursing	1,000	1,039	36,465	35.10	2
3	Registered Nurses	14,553	16,144	475,941	29.48	3
4	Licensed Practical Nurses	22,087	23,433	499,255	21.31	4
5	CNAs & Orderlies	75,182	79,284	1,346,846	16.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,513	3,757	35,055	9.33	9
10	Activity Assistants	2,056	2,309	22,969	9.95	10
11	Social Service Workers	8,619	9,320	142,196	15.26	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,105	35,249	16.75	13
14	Head Cook	3,334	3,737	33,798	9.04	14
15	Cook Helpers/Assistants	17,613	18,725	174,062	9.30	15
16	Dishwashers					16
17	Maintenance Workers	6,099	6,631	94,021	14.18	17
18	Housekeepers	8,587	9,128	93,001	10.19	18
19	Laundry	4,616	4,927	42,357	8.60	19
20	Administrator	2,048	2,240	219,100	97.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,174	11,892	152,291	12.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,008	2,171	32,175	14.82	31
32	Other Health C: Marketing	2,249	2,443	87,483	35.81	32
33	Other(specify) Apt/Congregate	36,833	39,642	856,303	21.60	33
34	TOTAL (lines 1 - 33)	224,283	242,847	$ 4,532,515 *	$ 18.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	369	$ 21,394	V01-3	35
36	Medical Director	340	18,000	V09-3	36
37	Medical Records Consultant	32	1,600	V10-3	37
38	Nurse Consultant	8	400	V10-3	38
39	Pharmacist Consultant	8	6,489	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	4,702	V11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	819	$ 52,585		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,513	$ 268,141	V10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,513	$ 268,141		53

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Brown	Administrator		$ 219,100
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 219,100

B. Administrative - Other

Description	Amount
Management Fee	$ 585,824
TOTAL (agree to Schedule V, line 17, col. 3)	$ 585,824
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Survey	$ 1,456
Davis & Campbell	Collections	2,061
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 3,517

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,317
Unemployment Compensation Insurance	6,797
FICA Taxes	333,748
Employee Health Insurance	264,362
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	8,299
Employee Uniforms	1,111
Employee Expense	9,300
457 Plan Expense	2,438
Home Office Allocation	79,362
TOTAL (agree to Schedule V, line 22, col.8)	$ 769,734

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	123
Lobbying Expense	(477)
License	6,549
Dues	18,601
Subscriptions	4,371
Home Office Adjustment	4,774
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,141
In-State Travel	582
Seminar Expense	443
Home Office Allocation	17,819
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,985

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hickorypoint Christian Vill # 0050682 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Leading Age - $11,943.44**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,015** 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. $ **102,509**
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. $ **13,457**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
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? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Plante Moran PLLC**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.