FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0004630

Facility Name: Christian Nursing Home

Address: 1507 7th Street (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: 217-732-2189 **Fax #** 217-732-1904

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1965

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Susan McGhee **Telephone Number:** 314-587-7903
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 July 1, 2009 to June 30, 2010 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) Tim Phillippe
(Title) Chief Executive Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington Ave, Ste 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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 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	112	Skilled (SNF)	112	40,880	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	112	TOTALS	112	40,880	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	16,082	16,316	5,304	37,702	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,082	16,316	5,304	37,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.23%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, Lawn & Maint Care, Housekeeping & Landry 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 09/01/1995

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 112 and days of care provided 5,041

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	236,095	31,434	5,326	272,855		272,855		272,855			1
2	Food Purchase		274,212		274,212		274,212	(2,665)	271,547			2
3	Housekeeping	153,927	31,346		185,273		185,273		185,273			3
4	Laundry	50,050	4,709	197,130	251,889		251,889		251,889			4
5	Heat and Other Utilities							(8,763)	(8,763)			5
6	Maintenance	91,360	9,154	72,551	173,065		173,065	3,850	176,915			6
7	Other (specify):*											7
8	TOTAL General Services	531,432	350,855	275,007	1,157,294		1,157,294	(7,578)	1,149,716			8
	B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600			9
10	Nursing and Medical Records	2,505,070	386,895	32,360	2,924,325	(163,279)	2,761,046		2,761,046			10
10a	Therapy		4,338	634,318	638,656		638,656		638,656			10a
11	Activities	97,716			97,716		97,716	539	98,255			11
12	Social Services	95,706	7,772	23,664	127,142		127,142		127,142			12
13	CNA Training											13
14	Program Transportation			4,421	4,421		4,421	(3,283)	1,138			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,698,492	399,005	697,363	3,794,860	(163,279)	3,631,581	(2,744)	3,628,837			16
	C. General Administration											
17	Administrative	65,383	3,121	583,978	652,482		652,482	(357,853)	294,629			17
18	Directors Fees											18
19	Professional Services			3,025	3,025		3,025	30,051	33,076			19
20	Dues, Fees, Subscriptions & Promotions			18,979	18,979		18,979		18,979			20
21	Clerical & General Office Expenses	119,071	12,748	95,884	227,703		227,703	147,704	375,407			21
22	Employee Benefits & Payroll Taxes			677,486	677,486		677,486	28,966	706,452			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,146	19,146		19,146	14,138	33,284			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,769	63,769		63,769	1,143	64,912			26
27	Other (specify):* Marketing	46,244	1,894	16,446	64,584		64,584	(64,584)				27
28	TOTAL General Administration	230,698	17,763	1,478,713	1,727,174		1,727,174	(200,435)	1,526,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,460,622	767,623	2,451,083	6,679,328	(163,279)	6,516,049	(210,757)	6,305,292			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 Christian Nursing Home #0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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			254,885	254,885		254,885	18,964	273,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,593	66,593		66,593	(59,548)	7,045			32
33	Real Estate Taxes			1,259	1,259		1,259	(1,259)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,660	36,660		36,660		36,660			35
36	Other (specify):* **Financing Fees**			1,620	1,620		1,620		1,620			36
37	**TOTAL Ownership**			361,017	361,017		361,017	(41,843)	319,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			49,006	49,006	163,279	212,285		212,285			39
40	Barber and Beauty Shops		33	28,105	28,138		28,138		28,138			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* **Apt/Congregate**			526,081	526,081		526,081	(532,908)	(6,827)			43
44	**TOTAL Special Cost Centers**		33	664,512	664,545	163,279	827,824	(532,908)	294,916			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,460,622	767,656	3,476,612	7,704,890		7,704,890	(785,508)	6,919,382			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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	(2,332)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,917)	5		5
6	Rented Facility Space	(1,181)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(66,593)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(13,928)	21		24
25	Fund Raising, Advertising and Promotional	(64,584)	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	(543,664)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (707,199)		$	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)	(78,309)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (78,309)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (785,508)		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	X		163,279	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 163,279		47

Christian Nursing Home

ID# 0004630

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (333)	2	1
2	Activity	539	11	2
3	Transporation	(3,283)	14	3
4	Apt / Congregate	(532,908)	43	4
5	RE Tax on Vacant Lots	(1,259)	33	5
6	Charity Care	(6,420)	21	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**	(543,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,665)	0	0	0	0	0	0	0	0	0	0	(2,665)	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	(16,098)	7,335	0	0	0	0	0	0	0	0	0	(8,763)	5
6	Maintenance	0	3,850	0	0	0	0	0	0	0	0	0	3,850	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,763)	11,185	0	0	0	0	0	0	0	0	0	(7,578)	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	539	0	0	0	0	0	0	0	0	0	0	539	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	(3,283)	0	0	0	0	0	0	0	0	0	0	(3,283)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,744)	0	0	0	0	0	0	0	0	0	0	(2,744)	16
	C. General Administration													
17	Administrative	0	(357,853)	0	0	0	0	0	0	0	0	0	(357,853)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,051	0	0	0	0	0	0	0	0	0	30,051	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(20,348)	168,052	0	0	0	0	0	0	0	0	0	147,704	21
22	Employee Benefits & Payroll Taxes	0	28,966	0	0	0	0	0	0	0	0	0	28,966	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,138	0	0	0	0	0	0	0	0	0	14,138	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	1,143	0	0	0	0	0	0	0	0	0	1,143	26
27	Other (specify):*	(64,584)	0	0	0	0	0	0	0	0	0	0	(64,584)	27
28	**TOTAL General Administration**	(84,932)	(115,503)	0	0	0	0	0	0	0	0	0	(200,435)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(106,439)	(104,318)	0	0	0	0	0	0	0	0	0	(210,757)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	18,964	0	0	0	0	0	0	0	0	0	18,964	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66,593)	7,045	0	0	0	0	0	0	0	0	0	(59,548)	32
33	Real Estate Taxes	(1,259)	0	0	0	0	0	0	0	0	0	0	(1,259)	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**	(67,852)	26,009	0	0	0	0	0	0	0	0	0	(41,843)	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):*	(532,908)	0	0	0	0	0	0	0	0	0	0	(532,908)	43
44	**TOTAL Special Cost Centers**	(532,908)	0	0	0	0	0	0	0	0	0	0	(532,908)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(707,199)	(78,309)	0	0	0	0	0	0	0	0	0	(785,508)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of board of directors.						

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 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 Homes, Inc.	100.00%	$ 7,335	$ 7,335	1
2	V	6	Maintenance				3,850	3,850	2
3	V	17	Administration	422,363			64,510	(357,853)	3
4	V	19	Professional Services				30,051	30,051	4
5	V	21	Clerical				168,052	168,052	5
6	V	22	Employee Benefits				28,966	28,966	6
7	V	24	Travel & Seminar				14,138	14,138	7
8	V	26	Insurance				1,143	1,143	8
9	V	30	Depreciation				18,964	18,964	9
10	V	32	Interest				7,045	7,045	10
11	V								11
12	V								12
13	V								13
14	Total			$ 422,363			$ 344,054	$ * (78,309)	14

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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 not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: ne 30, 2010

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 not applicable.				$	$		$	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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	Renovation Projects		6/30/07	$ 459,102	$ 459,102	6/30/2031	0.0567	$ 22,098	1
2	Bond Fund	X		Debt Restructure	$2,125.00	Various*	1,025,000	762,915	6/30/2032	Various*	44,495	2
3	*this is an allocation of the total GO bond debt which includes several different series with several different rates of interest											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,125.00		$ 1,484,102	$ 1,222,017			$ 66,593	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,484,102	$ 1,222,017			$ 66,593	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.)**

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-036-031-00	See Attached	$ 923.00	$
2.	12-623-005-00	See Attached	$ 314.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,237.00	$

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 a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior Brick Frame Steel 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 Building
Duplexes

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	42,000	Various	$ 83,965	1
2	Home Office Allocation			5,250	2
3	TOTALS	42,000		$ 89,215	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	48		1965	1965	$ 272,125	$ 5,522	54	$ 5,522	$	$ 265,953	4
5	26		1969	1969	282,500	6,152	50	6,152		277,577	5
6	26		1972	1972	318,878	7,351	47	7,351		314,238	6
7	12			2000	1,279,292	31,982	40	31,982		311,827	7
8	Home Office Allocation				54,152	4,023		4,023		107,955	8
	Improvement Type**										
9	Building Improvement			1965	48,022		20				9
10	Building Improvement			1969	49,853		20				10
11	Building Improvement			1972	56,049		20				11
12	Insulation/Fire Doors			1979	11,989	266	45	266		8,281	12
13	Windows & Improvements			1980	36,891	1,085	35	1,085		32,822	13
14	Water Sentry			1980	604		5			604	14
15	Furnace			1981	2,005		15			2,005	15
16	Laundry Room			1981	4,253	125	34	125		3,690	16
17	Folding Door			1982	429		20			429	17
18	Cooling Unit			1982	7,070		15			7,070	18
19	Garage			1982	2,875		15			2,875	19
20	Roofing			1982	9,373		5			9,373	20
21	Heating Control System			1983	8,969		15			8,969	21
22	Fan			1983	243		10			243	22
23	Roof Repairs			1983	34,602		15			34,602	23
24	Office Lights			1984	487		10			487	24
25	Water Heaters			1984	2,661		15			2,661	25
26											26
27	Kitchen Doors			1984	2,008		20			2,008	27
28	Compartment			1984	264		10			264	28
29	Wallpapering			1985	5,014		5			5,014	29
30	Roof Repairs			1985	50,063		5			50,063	30
31	Glazing Panels			1985	17,986	659	25	659		17,986	31
32	Windows			1985	7,800	223	35	223		5,590	32
33	Condensing Unit			1985	1,735		10			1,735	33
34	Cabinet & Sink Tops			1986	2,302		15			2,302	34
35	Building Improvement			1986	8,250	330	25	330		7,975	35
36	Gravel Roof			1986	2,986		15			2,986	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Access Panel	1986	$ 111	$	20	$	$	$ 111	37
38	A/C Unit	1986	10,500		20			10,500	38
39	Wall Cabinet	1986	191		10			191	39
40	Laundry Floor Cover	1986	1,157		5			1,157	40
41	Drapes	1986	2,282		5			2,282	41
42	Laundry Room	1986	26,110		20			26,110	42
43	Laundry Floor	1987	3,196		5			3,196	43
44	Sprinkler System	1987	120		20			120	44
45	Wall Bumper	1987	211		20			211	45
46	Fire Alarm	1987	499		20			499	46
47	Life Safety Work	1987	9,104		20			9,104	47
48	Life Safety	1987	266		10			266	48
49	Shuttering	1987	893		20			893	49
50	Wallcovering	1987	285		5			285	50
51	Carpeting	1987	1,817		5			1,817	51
52	Beauty Shop Floor	1987	618		5			618	52
53	Remodeling	1987	200		10			200	53
54	Life Safety	1987	1,284		10			1,284	54
55	Chaplains Office	1987	667		5			667	55
56	Life Safety	1987	1,875		10			1,875	56
57	Cabinets Beauty Shop	1987	558		15			558	57
58	Glass Windows	1987	2,396		20			2,396	58
59	Lights	1987	364		10			364	59
60	Metal Door	1987	440		20			440	60
61	Water Heater	1987	4,701		10			4,701	61
62	3-Ply Pitch Roof	1988	6,150		15			6,150	62
63	New A/C Work	1989	6,066		20			6,066	63
64	A/C System	1989	42,748		20			42,748	64
65	Ceiling Tiles	1989	351		5			351	65
66	Fire Dampers	1989	1,881		10			1,881	66
67	Replace Door	1989	657	3	20	3		657	67
68	Condensing Unit	1989	700		5			700	68
69	Sprinkler System	1989	4,106	34	20	34		4,106	69
70	TOTAL (lines 4 thru 69)		$ 2,714,234	$ 57,755		$ 57,755	$	$ 1,620,088	70

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 2,714,234	$ 57,755		$ 57,755	$	$ 1,620,088	1
2	Life Safety	1989	458		10			458	2
3	Stain Glass Windows	1989	475		10			475	3
4	Remodel Dining Room	1990	2,970		10			2,970	4
5	Circulating Pump	1990	705		15			705	5
6	Replace /Install Window	1990	710	20	35	20		407	6
7	Doors	1990	508	26	20	26		506	7
8	Roofing A/C	1990	1,732		15			1,732	8
9	Water Heater	1990	2,275		15			2,275	9
10	A/C Unit	1990	10,186		10			10,186	10
11	Wallpaper	1991	2,544		5			2,544	11
12	Modular Nurse Station	1991	9,321		10			9,321	12
13	Roll Cover Base	1991	599		10			599	13
14	Wallpaper	1991	1,807		5			1,807	14
15	Wallcoverings	1991	5,774		5			5,774	15
16	A/C Compressor	1991	7,007		10			7,007	16
17	Cafeteria Window	1991	711	20	35	20		388	17
18	Base Cabinet	1991	666		15			666	18
19	Roof Work	1991	2,900		15			2,900	19
20	Water Heater	1991	1,288		15			1,288	20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		23,044	21
22	Life Safety	1992	814		20			814	22
23	Doors (5)	1992	2,550	128	20	128		2,327	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		1,127	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		1,255	26
27	Life Safety	1992	973		20			973	27
28	Furnaces	1992	13,165	658	20	658		11,684	28
29	Wall Paper	1992	3,376		5			3,376	29
30	Lighting	1993	954		10			954	30
31	Air Conditioner	1993	4,475		10			4,475	31
32	Reroof	1993	8,477	385	22	385		6,582	32
33	SW Roof	1993	900	41	22	41		689	33
34	TOTAL (lines 1 thru 33)		$ 2,830,789	$ 60,415		$ 60,415	$	$ 1,729,987	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,830,789	$ 60,415		$ 60,415	$	$ 1,729,987	1
2	Furnaces	1993	4,570	229	20	229		3,808	2
3	Lighting Life Safety	1994	973		10			973	3
4	Panels/Base Dayroom	1994	860		5			860	4
5	Drive Up/Curb Canopy	1994	7,108		10			7,108	5
6	Door Alarms	1994	851		5			851	6
7	Doors	1994	1,319		10			1,319	7
8	Front Entrance	1995	11,006		10			11,006	8
9	Roof	1995	6,300		5			6,300	9
10	Roof	1995	15,582		10			15,582	10
11	Front Entrance	1996	7,125		10			7,125	11
12	Roof Work	1996	3,400		5			3,400	12
13	Cnds. Unit-100	1996	2,742		10			2,742	13
14	Roof Work	1996	536		5			536	14
15	Roof Work Ewing	1996	3,062		5			3,062	15
16	Roof Repairs	1996	1,279		5			1,279	16
17	Lights & Dampers	1997	17,712		10			17,712	17
18	Courtyard Door	1997	972		10			972	18
19	Office Roof Work	1997	2,275		5			2,275	19
20	Roof Work 100 Wing	1997	13,120		10			13,120	20
21	Floor Covering	1997	2,091		5			2,091	21
22	Roof Work N&S Wing	1998	12,500		10			12,500	22
23	South Wing Roof Work	1998	14,800		10			14,800	23
24	A/C in Lobby	1998	1,226		10			1,226	24
25	Compressor - Laundry	1998	1,914		3			1,914	25
26	Roof Work	1999	1,920		5			1,920	26
27	Roof Work - Valley Area	1999	5,073		5			5,073	27
28	Carpeting 300 Wing	1999	11,167		5			11,167	28
29	A/C Unit 300 Wing	1999	4,284		10			4,284	29
30	Roof Work Dining Area	1999	6,590		5			6,590	30
31	Wallpaper 300 Wing	1999	12,512		5			12,512	31
32	Carpet Conference	1999	978		5			978	32
33	Carpet Lobby	1999	5,021		5			5,021	33
34	TOTAL (lines 1 thru 33)		$ 3,011,657	$ 60,644		$ 60,644	$	$ 1,910,093	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,011,657	$ 60,644		$ 60,644	$	$ 1,910,093	1
2	Carpeting	1999	3,473		5			3,473	2
3	Office A/C Unit	1999	2,715		10			2,715	3
4	Carpeting	1999	1,743		5			1,743	4
5	Roof Work	1999	3,665		5			3,665	5
6	Remodel Beauty Shop	1999	1,339		5			1,339	6
7	Roof work	2000	5,536		5			5,536	7
8	Opto 22 energy management	2000	14,795	986	15	986		10,603	8
9	AD Smith water heater	2000	3,195	80	10	80		3,195	9
10	Water heater	2000	5,590	233	10	233		5,590	10
11	Handwash station	2000	1,140	76	15	76		798	11
12	Kitchen expansion	2000	790,605	19,765	40	19,765		204,240	12
13	Wallcover Staff DR	2000	933		5			933	13
14	Storage cabs	2000	676	45	15	45		466	14
15	Condensing unit	2000	2,530	169	15	169		1,701	15
16	Compressor laundry	2000	1,524	127	12	127		1,281	16
17	Heaters in Dayroom	2000	1,029	69	15	69		663	17
18	Wallpaper Secretary Office	2001	2,943		5			2,943	18
19									19
20	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		24,672	20
21	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		4,708	21
22	12 SMOKE DETECTORS	2001	1,504	150	10	150		1,404	22
23	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		1,453	23
24	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		636	24
25	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		509	25
26	Compressors Etc, 300 Wing	2001	1,732		3			1,732	26
27	3 Swinging Fire Doors W/ Frames	2001	12,304	1,230	10	1,230		10,766	27
28	Main Breaker - NH	2001	4,718	472	10	472		4,089	28
29	Vinyl For Various Ares	2001	8,528		5			8,528	29
30	Carpeting - Activity Room	2001	15,290		5			15,290	30
31									31
32	Roof Repairs	2002	2,211	221	10	221		1,824	32
33	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		4,123	33
34	TOTAL (lines 1 thru 33)		$ 3,940,539	$ 88,184		$ 88,184	$	$ 2,240,711	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,940,539	$ 88,184		$ 88,184	$	$ 2,240,711	1
2	(2) Hot water holding tanks	11/18/2002	9,434	629	15	629		4,822	2
3	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	510	10	510		3,698	3
4	Carpet/Wallpaper - Administrators Office	5/28/2003	2,555		5			2,555	4
5	Roof Repairs - 200 Hall	6/9/2003	4,600	460	10	460		3,258	5
6	10 x12 Storage shed	6/10/1999	1,578		10			1,578	6
7	Fully depreciated land improvements	6/30/1975	104,621		20			104,621	7
8	Landscaping and plants	5/23/1989	686		20			686	8
9	Survey and land clearing	5/7/1992	3,350	168	20	168		3,043	9
10	Fence, garbage area	9/30/1992	542		10			542	10
11	Landscaping entrance	5/4/1995	1,273		10			1,273	11
12	Landscaping, patio, water, lights	8/21/2000	30,266	3,026	10	3,026		29,844	12
13	Shuffleboard court	6/1/2003	785		5			785	13
14	Wallpaper 100/200 Wing - Dining Room	1/29/2004	12,387		5			12,387	14
15	Roof repair/Rehab/Nurs Stat/Day Room	10/22/2003	46,500	4,650	10	4,650		31,388	15
16	High Efficiency Ballasts/Lights	11/25/2003	15,076	1,508	10	1,508		10,051	16
17	Office Telephone System	1/15/2004	8,146		5			8,146	17
18	Business Office - Sound Proofing	12/1/2003	1,506	151	10	151		991	18
19	PT Room Renovation	1/31/2004	4,407		5			4,407	19
20	Conference Room Remodeling	1/31/2004	846		5			846	20
21	Smoke Detectors - Telephone & OT Office	3/25/2004	1,333	133	10	133		844	21
22	Network Cabling	2/16/2004	6,825	683	10	683		4,379	22
23	Smoke Detectors - Resident Rooms	4/14/2004	3,707	371	10	371		2,317	23
24	(20) Smoke alarms in Nursing home	4/20/2004	1,617	162	10	162		1,011	24
25									25
26	Roof Repairs - 400 Wing	6/14/2004	4,500	450	10	450		2,738	26
27									27
28	3 Ton A/C for Laundry	6/30/2004	2,386	239	10	239		1,451	28
29	A/C Unit - 100 Hall	6/30/2004	1,231	123	10	123		749	29
30	(4) Call Cord Stations	10/20/2004	770	38	5	38		770	30
31	Remodel Front Entrance/Business Office	10/1/2004	11,056	553	5	553		11,056	31
32	Install Dampers/Misc Energy Mgmt Work	3/11/2005	1,434		3			1,434	32
33	Roof Repairs	3/29/2005	32,938	3,294	10	3,294		17,294	33
34	TOTAL (lines 1 thru 33)		$ 4,261,994	$ 105,332		$ 105,332	$	$ 2,509,675	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,261,994	$ 105,332		$ 105,332	$	$ 2,509,675	1
2	Add'l Smoke Detectors (Life Safety)	3/25/2005	1,585	159	10	159		845	2
3	Generator Upgrade (Life Safety)	4/1/2005	2,621	262	10	262		1,376	3
4	Fireproof Window Casing in Business Office	4/6/2005	1,823	273	5	273		1,823	4
5	Therapy Room Painting	7/7/2005	500	100	5	100		500	5
6	Therapy Room Improvements	7/4/2005	1,098	110	10	110		549	6
7	Mural Painting In Therapy Gym	9/15/2005	3,000	600	5	600		2,900	7
8	Therapy Area New Flooring	7/11/2005	3,460	692	5	692		3,460	8
9	Window For 300 Wing Day Room	1/1/2006	750	75	10	75		338	9
10	Roof Repairs Over 300 Hall	11/30/2005	11,800	1,180	10	1,180		5,507	10
11	(14) GE Zoneline AC Units For 300	4/13/2006	15,400	3,080	5	3,080		13,090	11
12	Parking Lot South Side of Bldg	6/26/2006	14,700	980	15	980		3,920	12
13	Sidewalk Between Nursing Home	4/13/2006	3,795	380	10	380		1,614	13
14	Rock & Delivery For Parking Lot On N	11/14/2005	878	176	5	176		820	14
15									15
16	Front foor and 300 hall SE door	12/29/2006	3,794	253	15	253		906	16
17	Install Laundry RTU & 30x20	8/8/2006	6,113	611	10	611		2,394	17
18	Install new floor in dining room	1/9/2007	3,155	631	5	631		2,208	18
19									19
20	Install tile flooring Nurses Station	2/1/2007	5,752	288	20	288		983	20
21	Install tile flooring Nurses Station	3/1/2007	1,355	68	20	68		226	21
22									22
23									23
24									24
25									25
26	81 Gallon Commercial hot water heater	9/14/2007	5,261	526	10	526		1,491	26
27									27
28									28
29	Kitchen Flooring	3/21/2008	19,500	1,950	10	1,950		4,550	29
30	Add & Move Fire Alarms	3/31/2008	3,336	334	10	334		778	30
31									31
32									32
33	Kitchen Project	5/23/2008	681	68	10	68		148	33
34	TOTAL (lines 1 thru 33)		$ 4,372,351	$ 118,128		$ 118,128	$	$ 2,560,101	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,372,351	$ 118,128		$ 118,128	$	$ 2,560,101	1
2	Kitchen Remodeling Project - Sink	5/31/2008	3,457	346	10	346		750	2
3	Install new 100 Wing exit door	6/20/2008	18,396	1,840	10	1,840		3,833	3
4	Kitchen Remodeling Project-	6/30/2008	4,821	482	10	482		1,004	4
5									5
6									6
7									7
8									8
9									9
10	Paving, extended parking lots, 2 new exits	5/10/2008	15,137	1,514	10	1,514		3,280	10
11	Handrails outside of building	5/30/2008	17,013	1,701	10	1,701		3,686	11
12	white vinyl fencing	6/19/2008	3,580	358	10	358		746	12
13									13
14									14
15	Roofing - shingles and labor	7/22/2008	21,000	2,100	10	2,100		4,200	15
16	Glass sliding door - Dayroom	8/27/2008	2,500	250	10	250		479	16
17									17
18	Plank flooring	9/8/2008	7,268	727	10	727		1,332	18
19	Roof	9/20/2008	3,410	341	10	341		625	19
20									20
21	Hot water boiler & installation	2/27/2009	10,748	1,075	10	1,075		1,523	21
22									22
23									23
24	Accutech Resident Security System	4/28/2009	59,164	5,916	10	5,916		7,391	24
25	Sprinkler Project - Architect	6/1/2009	1,503	150	10	150		163	25
26	Rooftop A/C units	6/19/2009	5,500	550	10	550		596	26
27	2 A/C Rooftop units	6/23/2009	16,000	1,600	10	1,600		1,733	27
28	A/C coil - 100 hallway	6/19/2009	3,542	708	5	708		767	28
29	Landscaping - front entrance, main building	7/28/2008	2,062	206	10	206		412	29
30	Landscaping - flag pole and Alzheimer's area	7/28/2008	1,214	121	10	121		242	30
31	Courtyard Patio & Sidewalk repair	4/5/2010	6,047	151	10	151		151	31
32	2 Ton Air Handler in Attic	7/6/2009	1,165	116	10	116		116	32
33	Grease Trap for Kitchen	7/6/2009	5,156	516	10	516		516	33
34	**TOTAL (lines 1 thru 33)**		$ 4,581,034	$ 138,896		$ 138,896	$	$ 2,593,646	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,581,034	$ 138,896		$ 138,896	$	$ 2,593,646	1
2	Boiler Replacement	8/17/2009	113,000	5,179	20	5,179		5,179	2
3	Roofing - Kitchen	8/4/2009	6,500	596	10	596		596	3
4	Roofing - 200 Wing	8/4/2009	8,000	733	10	733		733	4
5	Delay Egress Locks, Keypad	8/17/2009	4,854	445	10	445		445	5
6	Horton 4100LE HD-Swing	9/21/2009	2,089	174	10	174		174	6
7	Environmental Study	10/15/2009	3,135	235	10	235		235	7
8	Exterior Soffit Work	8/11/2009	14,844	1,361	10	1,361		1,361	8
9	Additional Costs Related to Boiler Repl	3/13/2010	10,500	350	10	350		350	9
10	Courtyard Soffit Work	3/31/2010	13,440	448	10	448		448	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	TOTAL (lines 1 thru 33)		$ 4,757,396	$ 148,417		$ 148,417	$	$ 2,603,167	34

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 612,051	$ 75,266	$ 75,266	$	Various	$ 334,541	71
72	Current Year Purchases	140,257	9,720	9,720		Various	16,556	72
73	Fully Depreciated Assets	538,459	11,613	11,613		Various	538,459	73
74	Home Office Allocation	173,608	12,897	12,897			26,416	74
75	TOTALS	$ 1,464,375	$ 109,496	$ 109,496	$		$ 915,972	75

D. Vehicle Depreciation (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	See Detail Attachment		$ 57,140	$ 8,249	$ 8,249	$		$ 9,305	76
77	Patient Transportation	2000 Chevy Van Lift	9/9/2003	8,432				3	8,432	77
78	Patient Transportation	1998 Buick LeSabre Custom Seda	3/1/2010	4,240	353	353		4	353	78
79	Home Office Allocation			27,508	2,044	2,044			9,713	79
80	TOTALS			$ 97,320	$ 10,646	$ 10,646	$		$ 27,803	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)	$ 6,408,306	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 268,560	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 268,560	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)	$ 3,546,943	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	1999 Ford Ranger - 4/11/06	$ 4,800	$	$ 4,800	86
87	5' x 14' Tandem Axel Trailer - 4/11/06	900	113	450	87
88	Land	230,405			88
89	Apartment/Congregate	2,230,013	64,493	1,420,694	89
90	Duplex	2,278,498	59,498	1,534,747	90
91	TOTALS	$ 4,744,616	$ 124,104	$ 2,960,691	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 39,699	92
93			93
94			94
95		$ 39,699	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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 36,660 Description: See Attached Detail Schedule
(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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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.

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 ____

The Christian Village does not train C N As. They hire them already certified.

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.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	$	3,774	$ 256,997	$	3,774	$ 256,997	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,006	96,416		1,006	96,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		4,341	280,905		4,341	280,905	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	9,121	$ 634,318	$	9,121	$ 634,318	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.

STATE OF ILLINOIS

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2010 (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	$ 4,714,559	$	1
2	Cash-Patient Deposits	16,246		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 38,964)	548,275		3
4	Supply Inventory (priced at)	26,279		4
5	Short-Term Investments	503,270		5
6	Prepaid Insurance	321		6
7	Other Prepaid Expenses	9,921		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	13,305		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,832,176	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,370		13
14	Buildings, at Historical Cost	8,820,801		14
15	Leasehold Improvements, at Historical Cost	297,575		15
16	Equipment, at Historical Cost	1,620,248		16
17	Accumulated Depreciation (book methods)	(6,427,563)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,860,774		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	214,257		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,700,462	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,532,638	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,330	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,246		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,211		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	618		32
33	Accrued Interest Payable	4,222		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	76,814		36
37	Refundable Wait List Deposits	10,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 585,441	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,222,017		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Apartment Income	863,570		43
44	Apt & Cong Life Right & Sec	678,734		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,764,321	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,349,762	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,182,876	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,532,638	$	48

*(See instructions.)

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,939,474	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,939,474	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	243,403	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 243,403	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)**	$ 9,182,877	24 *

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,480,035	1
2	Discounts and Allowances for all Levels	(1,689,250)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,790,785	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,913,110	6
7	Oxygen	1,744	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,914,854	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	29,188	13
14	Non-Patient Meals	2,332	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,181	16
17	Sale of Drugs	539	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	51,223	19
20	Radiology and X-Ray	29,411	20
21	Other Medical Services	17,366	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,240	23
	D. Non-Operating Revenue		
24	Contributions	143,910	24
25	Interest and Other Investment Income***	72,745	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 216,655	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential/Congregate - See Groupings	800,913	28
28a	Unrealized Gain/Loss & Miscellaenous Income - See Grou	93,846	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 894,759	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,948,293	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,157,294	31
32	Health Care	3,794,860	32
33	General Administration	1,727,174	33
	B. Capital Expense		
34	Ownership	361,017	34
	C. Ancillary Expense		
35	Special Cost Centers	603,225	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,704,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	243,403	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 243,403	43

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

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

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	1,759	1,759	$ 74,615	$ 42.42	1
2	Assistant Director of Nursing	2,066	2,066	78,101	37.80	2
3	Registered Nurses	9,727	11,202	336,287	30.02	3
4	Licensed Practical Nurses	32,263	35,855	655,097	18.27	4
5	CNAs & Orderlies	92,170	100,772	1,075,815	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,836	3,836	57,795	15.07	8
9	Activity Director	1,735	1,735	21,038	12.13	9
10	Activity Assistants	7,226	7,226	76,678	10.61	10
11	Social Service Workers	5,315	6,517	95,706	14.69	11
12	Dietician					12
13	Food Service Supervisor	1,809	1,809	36,571	20.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,846	21,577	199,524	9.25	15
16	Dishwashers					16
17	Maintenance Workers	6,566	7,074	91,360	12.91	17
18	Housekeepers	14,148	14,862	153,927	10.36	18
19	Laundry	5,146	5,384	50,050	9.30	19
20	Administrator	737	737	65,383	88.72	20
21	Assistant Administrator					21
22	Other Administrative	1,088	1,088	31,998	29.41	22
23	Office Manager	1,917	1,917	33,248	17.34	23
24	Clerical	3,824	4,757	53,825	11.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,484	1,484	49,358	33.26	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Ward Clerk/MDS	8,558	8,558	178,002	20.80	32
33	Other(specify) Marketing	1,751	1,751	46,244	26.41	33
34	TOTAL (lines 1 - 33)	222,971	241,966	$ 3,460,622 *	$ 14.30	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	110	$ 5,323	1-3	35
36	Medical Director	6	2,600	9-3	36
37	Medical Records Consultant	16	2,488	10-3	37
38	Nurse Consultant	48	10,921	10-3	38
39	Pharmacist Consultant	156	3,020	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	103	6,560	12-3	45
46	Other(specify)				46
47	Utilization Review Committee	4	400	10-3	47
48	Administration	1,733	161,615	17-3	48
49	TOTAL (lines 35 - 48)	2,176	$ 192,927		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charlotte Bennett	Former Administrator	0	$ 46,951
Doug Rutter	Administrator	0	18,432
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,383

B. Administrative - Other

Description	Amount
Management Fee	$ 422,363
Contracted Salaries - Dennis DeCosta, Interim Administrator	161,615
TOTAL (agree to Schedule V, line 17, col. 3)	$ 583,978
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	Resident/Emp Surveys	$ 1,489
Davis & Campbell	Legal	1,445
Elvidge Kelley	Legal	91
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,025

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,862
Unemployment Compensation Insurance	37,924
FICA Taxes	264,471
Employee Health Insurance	264,737
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	8,383
Employee Expense	28,217
457 Plan Expense	3,000
Employee Uniforms	892
Home Office Allocation	28,966
TOTAL (agree to Schedule V, line 22, col.8)	$ 706,452

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,589
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License	2,865
Dues	8,355
Subscriptions	2,853
Admin Refresher Course	1,317
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,979

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	8,564
Seminar Expense	10,582
Home Office Allocation	14,138
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,284

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Christian Nursing Home **#** 0004630 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 201

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. **LSN $7,988**

(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?

(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?

(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. $ **19,244** 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.

(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. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,332**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **LarsonAllen LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.