FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 9/1/1965

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: 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, 2011 to June 30, 2012 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) Susan McGhee
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Allan B. Larson, Partner
(Firm Name & Address) CliftonLarsonAllen, 600 Washington Ave., Suite 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, 2011 Ending: June 30, 2012

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	40,992	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	40,992	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	17,988	15,550	4,468	38,006	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,988	15,550	4,468	38,006	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.72%

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 & 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 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 4,196

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: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	253,909	32,264	799	286,972		286,972		286,972			1
2	Food Purchase		269,109		269,109		269,109	(1,877)	267,232			2
3	Housekeeping	92,111	30,755		122,866		122,866		122,866			3
4	Laundry	69,101	5,911		75,012		75,012	12,269	87,281			4
5	Heat and Other Utilities			176,946	176,946		176,946	(17,356)	159,590			5
6	Maintenance	89,896	16,532	99,394	205,822		205,822	3,330	209,152			6
7	Other (specify):*											7
8	TOTAL General Services	505,017	354,571	277,139	1,136,727		1,136,727	(3,634)	1,133,093			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250		3,250			9
10	Nursing and Medical Records	2,637,945	213,410	19,311	2,870,666		2,870,666	(2,978)	2,867,688			10
10a	Therapy		1,715	550,997	552,712		552,712		552,712			10a
11	Activities	99,703	6,571		106,274		106,274		106,274			11
12	Social Services	110,937	3,042	14,875	128,854		128,854		128,854			12
13	CNA Training											13
14	Program Transportation	22,615		9,809	32,424		32,424	(5,994)	26,430			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,871,200	224,738	598,242	3,694,180		3,694,180	(8,972)	3,685,208			16
	C. General Administration											
17	Administrative	137,448	1,759	475,535	614,742		614,742	(402,068)	212,674			17
18	Directors Fees											18
19	Professional Services			4,422	4,422		4,422	38,745	43,167			19
20	Dues, Fees, Subscriptions & Promotions			18,075	18,075		18,075		18,075			20
21	Clerical & General Office Expenses	83,587	12,428	110,643	206,658		206,658	175,121	381,779			21
22	Employee Benefits & Payroll Taxes			849,141	849,141		849,141	36,597	885,738			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,971	8,971		8,971	13,405	22,376			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			60,871	60,871		60,871	(10,699)	50,172			26
27	Other (specify):* Marketing	49,985	998	19,959	70,942		70,942	(70,942)				27
28	TOTAL General Administration	271,020	15,185	1,547,617	1,833,822		1,833,822	(219,841)	1,613,981			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,647,237	594,494	2,422,998	6,664,729		6,664,729	(232,447)	6,432,282			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, 2011 Ending: June 30, 2012

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			267,793	267,793		267,793	26,803	294,596			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			178,503	178,503		178,503	(86,146)	92,357			32
33	Real Estate Taxes			1,330	1,330		1,330	(1,330)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,113	27,113		27,113		27,113			35
36	Other (specify):* **FIN 47 Accretion**			188	188		188		188			36
37	**TOTAL Ownership**			474,927	474,927		474,927	(60,673)	414,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			187,231	187,231		187,231	(9,728)	177,503			39
40	Barber and Beauty Shops		68	36,252	36,320		36,320		36,320			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,775	313,775		313,775		313,775			42
43	Other (specify):* **Apt/Congregate**			487,946	487,946		487,946	(487,946)				43
44	**TOTAL Special Cost Centers**		68	1,025,204	1,025,272		1,025,272	(497,674)	527,598			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,647,237	594,562	3,923,129	8,164,928		8,164,928	(790,794)	7,374,134			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, 2011 Ending: June 30, 2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,782)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,333)	5		5
6	Rented Facility Space	(1,342)	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	(86,146)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,885)	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				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	(27,582)	21		24
25	Fund Raising, Advertising and Promotional	(70,942)	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 PG 5A	(500,095)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (708,107)		$	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)	(82,687)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (82,687)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (790,794)		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

Christian Nursing Home

ID# 0004630

Report Period Beginning: July 1, 2011

Ending: June 30, 2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (5,994)	14	1
2	Vending	704	2	2
3	Apt / Congregate	(487,946)	43	3
4	RE Tax on Vacant Lots	(1,330)	33	4
5	Misc Revenue	(314)	21	5
6	Late Fees, Fines and Penalties	(1,538)	21	6
7	Insurance Gain	(2,774)	26	7
8	Late Fees	(799)	2	8
9	Late Fees	(11)	6	9
10	Late Fees	(93)	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**	(500,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home **#** 0004630 **Report Period Beginning:** July 1, 2011 **Ending:** June 30, 2012

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	(1,877)	0	0	0	0	0	0	0	0	0	0	(1,877)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	12,269	0	0	0	0	0	0	0	0	0	12,269	4
5	Heat and Other Utilities	(18,675)	1,319	0	0	0	0	0	0	0	0	0	(17,356)	5
6	Maintenance	(11)	3,341	0	0	0	0	0	0	0	0	0	3,330	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,563)	16,929	0	0	0	0	0	0	0	0	0	(3,634)	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	(2,978)	0	0	0	0	0	0	0	0	0	0	(2,978)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(5,994)	0	0	0	0	0	0	0	0	0	0	(5,994)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(8,972)	0	0	0	0	0	0	0	0	0	0	(8,972)	16
	C. General Administration													
17	Administrative	0	(402,068)	0	0	0	0	0	0	0	0	0	(402,068)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	38,745	0	0	0	0	0	0	0	0	0	38,745	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(29,434)	204,555	0	0	0	0	0	0	0	0	0	175,121	21
22	Employee Benefits & Payroll Taxes	0	36,597	0	0	0	0	0	0	0	0	0	36,597	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,405	0	0	0	0	0	0	0	0	0	13,405	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,774)	(7,925)	0	0	0	0	0	0	0	0	0	(10,699)	26
27	Other (specify):*	(70,942)	0	0	0	0	0	0	0	0	0	0	(70,942)	27
28	**TOTAL General Administration**	(103,150)	(116,691)	0	0	0	0	0	0	0	0	0	(219,841)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,685)	(99,762)	0	0	0	0	0	0	0	0	0	(232,447)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2011 **Ending:** June 30, 2012

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	26,803	0	0	0	0	0	0	0	0	0	26,803	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(86,146)	0	0	0	0	0	0	0	0	0	0	(86,146)	32
33	Real Estate Taxes	(1,330)	0	0	0	0	0	0	0	0	0	0	(1,330)	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**	(87,476)	26,803	0	0	0	0	0	0	0	0	0	(60,673)	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	(9,728)	0	0	0	0	0	0	0	0	0	(9,728)	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):*	(487,946)	0	0	0	0	0	0	0	0	0	0	(487,946)	43
44	**TOTAL Special Cost Centers**	(487,946)	(9,728)	0	0	0	0	0	0	0	0	0	(497,674)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(708,107)	(82,687)	0	0	0	0	0	0	0	0	0	(790,794)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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 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%	$ 1,319	$ 1,319	1
2	V	6	Maintenance				3,341	3,341	2
3	V	17	Administration	475,535			73,467	(402,068)	3
4	V	19	Professional Services				38,745	38,745	4
5	V	21	Clerical				171,475	171,475	5
6	V	22	Employee Benefits				36,597	36,597	6
7	V	4	Interest				12,269	12,269	7
8	V	24	Travel & Seminars				13,405	13,405	8
9	V	26	Insurance				(7,925)	(7,925)	9
10	V	30	Depreciation				26,803	26,803	10
11	V	21	Other Administrative Expense				33,080	33,080	11
12	V								12
13	V	39	Pharmacy Services	118,570	Senior Care Pharmacy	0.00%	108,842	(9,728)	13
14	Total			$ 594,105			$ 511,418	$ * (82,687)	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, 2011 Ending: June 30, 2012

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 worksheet 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, 2011 Ending: ne 30, 2012

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, 2011 Ending: June 30, 2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority Series 2007		X	Renovation Projects		6/30/2007	$ 382,171	$ 432,387	6/30/2031	5.6700	$ 22,216	1
2	Illinois Finance Authority Series 2010		X	Renovation Projects		7/31/2010	2,000,000	1,967,200	5/15/2027	6.1300	116,521	2
3	Bond Fund	X		Debt Relocation		***	843,874	694,814	6/30/2032	***	39,766	3
4		***this is an allocation of the total GO bond debt which includes several different series with several different rates of interest										4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,226,045	$ 3,094,401			$ 178,503	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,226,045	$ 3,094,401			$ 178,503	15

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

*** 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, 2011 Ending: June 30, 2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
2007		8
2008		9
2009		10
2010		11
2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-036-031-00	See Attached	$ 955.58	$
2.	12-623-005-00	See Attached	$ 325.06	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,280.64	$

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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, 2011 Ending: June 30, 2012

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			5,621	2
3	TOTALS	42,000		$ 89,586	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	48		1965	1965	$ 272,125	$ 650	54	$ 650	$	$ 272,125	4
5	26		1969	1969	282,500		50			282,500	5
6	26		1972	1972	318,878		47			318,878	6
7	12			2000	1,279,292	31,982	40	31,982		375,791	7
8	Home Office Allocation				55,076	6,251		6,251		33,937	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	Land Improvements			1975	103,638		20			103,638	12
13	Various			1979	11,989	266	Various	266		8,813	13
14	Various			1980	37,495	1,085	Various	1,085		35,596	14
15	Various			1981	2,005		Various			2,005	15
16	Various			1982	19,747		Various			19,747	16
17	Various			1983	43,814		Various			43,814	17
18	Various			1984	5,420		Various			5,420	18
19	Various			1985	77,584	223	Various	223		75,820	19
20	Various			1986	24,038		Various			24,038	20
21	Various			1987	21,279		Various			21,279	21
22	Various			1988	6,150		Various			6,150	22
23	Various			1989	58,128		Various			58,128	23
24	Various			1990	16,116	20	Various	20		15,853	24
25	Various			1991	12,572	20	Various	20		12,289	25
26	Various			1992	22,776	950	Various	950		22,611	26
27	Various			1993	18,422	655	Various	655		16,864	27
28	Various			1994	10,251		Various			10,251	28
29	Various			1995	32,888		Various			32,888	29
30	Various			1996	18,144		Various			18,144	30
31	Various			1997	34,079		Various			34,079	31
32	Various			1998	28,526		Various			28,526	32
33	Various			1999	30,276		Various			30,276	33
34	Various			2000	855,266	21,041	Various	21,041		305,410	34
35	Various			2001	59,289	465	Various	465		59,289	35
36	Various			2002	16,745	1,262	Various	1,262		13,391	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, 2011 Ending: June 30, 2012

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	Various	2003	$ 73,567	$ 7,279	Various	$ 7,279	$	$ 64,729	37
38	Various	2004	25,268	1,922	Various	1,922		22,545	38
39	Various	2005	51,494	4,736	Various	4,736		37,784	39
40	Various	2006	44,552	2,299	Various	2,299		29,170	40
41	Various	2007	5,261	526	Various	526		2,543	41
42	Various	2008	108,209	11,277	Various	11,277		44,706	42
43	Hot water boiler & installation	2/27/2009	10,748	1,075	10	1,075		3,673	43
44	Accutech Resident Security System	4/28/2009	59,164	5,916	10	5,916		19,223	44
45	Sprinkler Project - Architect	6/1/2009	1,503	150	10	150		463	45
46	Rooftop A/C units	6/19/2009	5,500	550	10	550		1,696	46
47	A/C coil - 100 hallway	6/19/2009	3,542	708	5	708		2,183	47
48	2 A/C Rooftop units	6/23/2009	16,000	1,600	10	1,600		4,933	48
49	2 Ton Air Handler in Attic	7/6/2009	1,165	116	10	116		348	49
50	Grease Trap for Kitchen	7/6/2009	5,156	516	10	516		1,548	50
51	Roofing - Kitchen	8/4/2009	6,500	650	10	650		1,896	51
52	Roofing - 200 Wing	8/4/2009	8,000	800	10	800		2,333	52
53	Exterior Soffit Work	8/11/2009	14,844	1,484	10	1,484		4,330	53
54	Boiler Replacement	8/17/2009	113,000	5,650	20	5,650		16,479	54
55	Delay Egress Locks, Keypad	8/17/2009	4,854	485	10	485		1,415	55
56	Horton 4100LE HD-Swing	9/21/2009	2,089	209	10	209		592	56
57	Environmental Study	10/15/2009	3,135	314	10	314		863	57
58	Additional Costs Related to Boiler Repl	3/13/2010	10,500	1,050	10	1,050		2,450	58
59	Courtyard Soffit Work	3/31/2010	13,440	1,344	10	1,344		3,136	59
60	Courtyard Patio & Sidewalk repair	4/5/2010	6,047	605	10	605		1,361	60
61	100 Hall - Install Fire Rated Door	7/31/2010	120	12	10	12		24	61
62	Landscaping for Sign	7/31/2010	446	45	10	45		89	62
63	Replacement Sewer Line	9/30/2010	9,939	994	10	994		1,822	63
64	Front Dayroom - Carpet	12/31/2010	2,225	222	10	222		352	64
65	300 Hall - Repaired Recirculation line	3/31/2011	1,095	110	10	110		146	65
66	Central Dayroom - Carpet	3/31/2011	656	66	10	66		88	66
67	Therapy Gym - Wall Cabinets	4/14/2011	201	20	10	20		25	67
68	400 Hall - Skylight Roof	4/30/2011	6,250	625	10	625		781	68
69	Chaplain Office - Carpet	6/30/2011	3,298	330	10	330		357	69
70	TOTAL (lines 4 thru 69)		$ 4,546,200	$ 118,555		$ 118,555	$	$ 2,561,633	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, 2011 Ending: June 30, 2012

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		$ 4,546,200	$ 118,555		$ 118,555	$	$ 2,561,633	1
2	100 Hall Shower Room - Whirlpool Tub	6/30/2011	8,508	851	10	851		922	2
3	Hot Water Heater	3/14/2012	5,188	173	10	173		173	3
4	100 wing A/C replacement	9/14/2011	2,609	217	10	217		217	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
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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)		$ 4,562,505	$ 119,796		$ 119,796	$	$ 2,562,945	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, 2011 Ending: June 30, 2012

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	$ 777,826	$ 100,823	$ 100,823	$		$ 435,554	71
72	Current Year Purchases	16,831	2,921	2,921			2,921	72
73	Fully Depreciated Assets	537,796	1,814	1,814			537,796	73
74	Home Office Allocation	222,647	18,654	18,654			95,278	74
75	TOTALS	$ 1,555,100	$ 124,212	$ 124,212	$		$ 1,071,549	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	See Detail Attachment		$ 102,688	$ 18,020	$ 18,020	$		$ 35,574	76
77	Patient Transportation	2000 Chevy Van Lift	9/9/2003	8,432				3		77
78	Patient Transportation	1998 Buick LeSabre Custom Sed	3/1/2010	4,240	1,060	1,060		4	2,454	78
79	Home Office Allocation			16,726	1,898	1,898			6,217	79
80	TOTALS			$ 132,086	$ 20,978	$ 20,978	$		$ 44,245	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)	$ 6,339,277	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 264,986	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 264,986	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)	$ 3,678,739	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 Truck	$ 4,800	$	$ 4,800	86
87	Tandem Axel Utility Trailer	900	113	694	87
88	Land	230,405			88
89	Apartment/Congregate	2,331,789	76,528	1,557,901	89
90	Duplex	2,328,035	56,960	1,640,382	90
91	TOTALS	$ 4,895,929	$ 133,601	$ 3,203,777	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 77,871	92
93	Campus Renovations	3,349,968	93
94			94
95		$ 3,427,839	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, 2011 Ending: June 30, 2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 34,939 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, 2011 Ending: June 30, 2012

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.

   The Christian Village 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.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	$	5,268	$ 204,287	$	5,268	$ 204,287	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,874	93,856		1,874	93,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,534	252,854		6,534	252,854	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			$	13,676	$ 550,997	$	13,676	$ 550,997	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, 2011 Ending: June 30, 2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2012 (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	$ 4,686,375	$	1
2	Cash-Patient Deposits	17,690		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,155)	919,934		3
4	Supply Inventory (priced at)	26,748		4
5	Short-Term Investments	561,388		5
6	Prepaid Insurance	350		6
7	Other Prepaid Expenses	14,113		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int/Other AR	35,437		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,262,035	$	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	8,690,230		14
15	Leasehold Improvements, at Historical Cost	305,135		15
16	Equipment, at Historical Cost	1,735,744		16
17	Accumulated Depreciation (book methods)	(6,819,640)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,149,066		21
22	Other Long-Term Assets (spe CIP	3,349,968		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,724,873	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,986,908	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 460,396	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,690		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,112		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	640		32
33	Accrued Interest Payable	19,431		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	571,348		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,294,617	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,094,401		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	799,542		43
44	Apt & Cong Life Right & Sec	645,507		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,539,450	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,834,067	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,152,841	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,986,908	$	48

*(See instructions.)

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,994,626	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,994,626	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,215	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)**	$ 158,215	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,152,841	24 *

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	$ 6,528,750	1
2	Discounts and Allowances for all Levels	(1,752,538)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,776,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,984,447	6
7	Oxygen	11,468	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,995,915	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	35,489	13
14	Non-Patient Meals	1,782	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,342	16
17	Sale of Drugs	227,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,993	19
20	Radiology and X-Ray	76,238	20
21	Other Medical Services	30,938	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 413,882	23
	D. Non-Operating Revenue		
24	Contributions	129,350	24
25	Interest and Other Investment Income***	86,146	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 215,496	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential/Congregate - See Groupings	857,185	28
28a	Unrealized Gain/Loss & Miscellaneous Income See Group	64,453	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 921,638	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,323,143	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,136,727	31
32	Health Care	3,694,180	32
33	General Administration	1,833,822	33
	B. Capital Expense		
34	Ownership	474,927	34
	C. Ancillary Expense		
35	Special Cost Centers	1,025,272	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,164,928	40
41	**Income before Income Taxes (line 30 minus line 40)****	158,215	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 158,215	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,226,300	44
45	Private Pay - Net Inpatient Revenue	2,678,391	45
46	Medicare - Net Inpatient Revenue	(127,115)	46
47	Other-(specify) HMO	(1,364)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,776,212	49

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

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

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	1,684	1,897	$ 65,000	$ 34.26	1
2	Assistant Director of Nursing	1,572	2,049	53,965	26.34	2
3	Registered Nurses	16,160	18,996	474,136	24.96	3
4	Licensed Practical Nurses	31,144	34,493	711,848	20.64	4
5	CNAs & Orderlies	94,764	100,972	1,172,905	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,925	2,045	25,003	12.23	9
10	Activity Assistants	6,367	6,989	61,765	8.84	10
11	Social Service Workers	8,390	9,291	146,215	15.74	11
12	Dietician	1,845	2,085	51,111	24.51	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,519	22,085	202,798	9.18	15
16	Dishwashers					16
17	Maintenance Workers	6,761	7,664	89,896	11.73	17
18	Housekeepers	10,616	11,174	92,911	8.31	18
19	Laundry	6,739	7,359	69,101	9.39	19
20	Administrator	4,047	4,472	137,448	30.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,790	2,098	34,525	16.46	23
24	Clerical	3,542	3,969	48,659	12.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,508	4,183	61,935	14.81	31
32	Other Health C: MDS	3,039	3,502	98,255	28.06	32
33	Other(specify) Marketing	1,852	2,333	49,761	21.33	33
34	TOTAL (lines 1 - 33)	226,264	247,656	$ 3,647,237 *	$ 14.73	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		$		35
36	Medical Director	48	3,250	1-3	36
37	Medical Records Consultant	32	2,343	9-3	37
38	Nurse Consultant	48	5,334	10-3	38
39	Pharmacist Consultant	84	2,523	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	75	4,966	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	287	$ 18,416		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, 2011 Ending: June 30, 2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie King	Asst Admin		$ 45,886
Douglas Rutter	Administrator		91,562
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 137,448

B. Administrative - Other

Description	Amount
Management Fee	$ 475,535
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 475,535

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	Professional Services	$ 1,770
Davis & Campbell	Legal	1,616
Cincinnati Insurance Company	Legal	1,036
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,422

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,292
Unemployment Compensation Insurance	43,836
FICA Taxes	278,244
Employee Health Insurance	379,050
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	15,405
Employee Uniforms	(787)
Employee Expense	21,921
457 Plan Expense	5,500
PTO	34,680
Home Office Allocation	36,597
TOTAL (agree to Schedule V, line 22, col.8)	$ 885,738

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	4,486
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
License	2,270
Dues	9,549
Subscriptions	1,770
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,075

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,680
Seminar Expense	4,291
Home Office Allocation	13,405
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,376

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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													
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10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2011 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/Leading Age, $8,243.85**

(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. $ **43,438** 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 **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **313,775**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,782**

(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: **CliftonLarsonAllen 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.