FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 St (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
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(c)(3)

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, 2012 to June 30, 2013 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) Steve Howell, Director
(Firm Name & Address) CliftonLarsonAllen, 600 Washington Ave., Suite 1800, St. Louis, MO 63101
(Telephone) (314) 925-4497 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, 2012 Ending: June 30, 2013

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	17,073	15,854	4,952	37,879	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,073	15,854	4,952	37,879	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.66%

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 4,803

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: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	273,968	29,787	365	304,120		304,120		304,120			1
2	Food Purchase		258,018		258,018		258,018	(1,767)	256,251			2
3	Housekeeping	106,740	26,271		133,011		133,011		133,011			3
4	Laundry	50,952	3,814		54,766		54,766	12,131	66,897			4
5	Heat and Other Utilities			161,229	161,229		161,229	(2,192)	159,037			5
6	Maintenance	100,396	13,899	104,285	218,580		218,580	3,856	222,436			6
7	Other (specify):*											7
8	TOTAL General Services	532,056	331,789	265,879	1,129,724		1,129,724	12,028	1,141,752			8
	B. Health Care and Programs											
9	Medical Director			25,333	25,333		25,333		25,333			9
10	Nursing and Medical Records	2,443,605	188,106	16,402	2,648,113		2,648,113	(4)	2,648,109			10
10a	Therapy		1,844	586,818	588,662		588,662		588,662			10a
11	Activities	52,816	4,405		57,221		57,221		57,221			11
12	Social Services	158,771	3,812	18,282	180,865		180,865		180,865			12
13	CNA Training											13
14	Program Transportation	21,997		8,053	30,050		30,050	(4,327)	25,723			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,677,189	198,167	654,888	3,530,244		3,530,244	(4,331)	3,525,913			16
	C. General Administration											
17	Administrative	91,878	1,452	472,206	565,536		565,536	(386,550)	178,986			17
18	Directors Fees											18
19	Professional Services			42,646	42,646		42,646	31,683	74,329			19
20	Dues, Fees, Subscriptions & Promotions			47,035	47,035		47,035		47,035			20
21	Clerical & General Office Expenses	105,128	10,264	88,178	203,570		203,570	209,056	412,626			21
22	Employee Benefits & Payroll Taxes			900,107	900,107		900,107	37,807	937,914			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,423	9,423		9,423	15,568	24,991			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			73,383	73,383		73,383	8,213	81,596			26
27	Other (specify):* Marketing	28,795	971	17,256	47,022		47,022	(47,022)				27
28	TOTAL General Administration	225,801	12,687	1,650,234	1,888,722		1,888,722	(131,245)	1,757,477			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,435,046	542,643	2,571,001	6,548,690		6,548,690	(123,548)	6,425,142			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, 2012 Ending: June 30, 2013

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			538,648	538,648		538,648	30,094	568,742			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184,135	184,135		184,135	(80,025)	104,110			32
33	Real Estate Taxes			1,307	1,307		1,307	(1,307)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,709	16,709		16,709		16,709			35
36	Other (specify):*											36
37	**TOTAL Ownership**			740,799	740,799		740,799	(51,238)	689,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			232,544	232,544		232,544	(11,038)	221,506			39
40	Barber and Beauty Shops		(164)	33,755	33,591		33,591		33,591			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,648	261,648		261,648		261,648			42
43	Other (specify):* **Apt/Congregate**	141,770		439,036	580,806		580,806	(541,935)	38,871			43
44	**TOTAL Special Cost Centers**	141,770	(164)	966,983	1,108,589		1,108,589	(552,973)	555,616			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,576,816	542,479	4,278,783	8,398,078		8,398,078	(727,759)	7,670,319			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, 2012 Ending: June 30, 2013

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	(1,767)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(3,492)	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	(80,025)	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	(3,408)	21		24
25	Fund Raising, Advertising and Promotional	(47,022)	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	(550,749)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (686,463)		$	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)	(41,296)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,296)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (727,759)		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, 2012

Ending: June 30, 2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (4,327)	14	1
2	Apt / Congregate	(541,935)	43	2
3	RE Tax on Vacant Lots	(1,307)	33	3
4	Late Fees, Fines and Penalties	(3,050)	21	4
5	Late Fees	(13)	6	5
6	Late Fees	(4)	10	6
7	Depreciation	(113)	30	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**	(550,749)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	12,131	0	0	0	0	0	0	0	0	0	12,131	4
5	Heat and Other Utilities	(3,492)	1,300	0	0	0	0	0	0	0	0	0	(2,192)	5
6	Maintenance	(13)	3,869	0	0	0	0	0	0	0	0	0	3,856	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,272)	17,300	0	0	0	0	0	0	0	0	0	12,028	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	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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	(4,327)	0	0	0	0	0	0	0	0	0	0	(4,327)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,331)	0	0	0	0	0	0	0	0	0	0	(4,331)	16
	C. General Administration													
17	Administrative	0	(386,550)	0	0	0	0	0	0	0	0	0	(386,550)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	31,683	0	0	0	0	0	0	0	0	0	31,683	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,458)	215,514	0	0	0	0	0	0	0	0	0	209,056	21
22	Employee Benefits & Payroll Taxes	0	37,807	0	0	0	0	0	0	0	0	0	37,807	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	15,568	0	0	0	0	0	0	0	0	0	15,568	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	8,213	0	0	0	0	0	0	0	0	0	8,213	26
27	Other (specify):*	(47,022)	0	0	0	0	0	0	0	0	0	0	(47,022)	27
28	**TOTAL General Administration**	(53,480)	(77,765)	0	0	0	0	0	0	0	0	0	(131,245)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,083)	(60,465)	0	0	0	0	0	0	0	0	0	(123,548)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2012 **Ending:** June 30, 2013

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	(113)	30,207	0	0	0	0	0	0	0	0	0	30,094	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(80,025)	0	0	0	0	0	0	0	0	0	0	(80,025)	32
33	Real Estate Taxes	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	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	(81,445)	30,207	0	0	0	0	0	0	0	0	0	(51,238)	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	(11,038)	0	0	0	0	0	0	0	0	0	(11,038)	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):*	(541,935)	0	0	0	0	0	0	0	0	0	0	(541,935)	43
44	TOTAL Special Cost Centers	(541,935)	(11,038)	0	0	0	0	0	0	0	0	0	(552,973)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(686,463)	(41,296)	0	0	0	0	0	0	0	0	0	(727,759)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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%	$ 1,300	$ 1,300	1
2	V	6	Maintenance				3,869	3,869	2
3	V	17	Administration	472,206			85,656	(386,550)	3
4	V	19	Professional Services				31,683	31,683	4
5	V	21	Clerical				179,488	179,488	5
6	V	22	Employee Benefits				37,807	37,807	6
7	V	4	Interest				12,131	12,131	7
8	V	24	Travel & Seminars				15,568	15,568	8
9	V	26	Insurance				8,213	8,213	9
10	V	30	Depreciation				30,207	30,207	10
11	V	21	Other Administrative Expense				36,026	36,026	11
12	V								12
13	V	39	Pharmacy Services	130,780	Senior Care Pharmacy		119,742	(11,038)	13
14	Total			$ 602,986			$ 561,690	$ * (41,296)	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, 2012 Ending: June 30, 2013

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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, 2012 Ending: ne 30, 2013

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, 2012 Ending: June 30, 2013

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	Refinance old debt		6/30/2007	$ 382,171	$ 418,014	6/30/2031	5.6700	$ 25,006	1
2	Illinois Finance Authority Series 2010		X	Refinance old debt		7/31/2010	2,000,000	1,954,800	5/15/2027	6.1300	123,312	2
3	Bond Fund	X		Debt Relocation	$3,314.00	***	843,874	657,636	6/30/2032	***	35,817	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				$3,314.00		$ 3,226,045	$ 3,030,450			$ 184,135	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	$ 3,030,450			$ 184,135	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, 2012 Ending: June 30, 2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-036-031-00	See Attached	$ 968.42	$
2.	12-623-005-00	See Attached	$ 329.80	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,298.22	$

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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, 2012 Ending: June 30, 2013

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			6,264	2
3	TOTALS	42,000		$ 90,229	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	$	54	$	$	$ 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		407,773	7
8	Home Office Allocation				61,377	6,970		6,970		40,513	8
	Improvement Type**										
9	Various			1965	153,924	19,026	Various	19,026		41,351	9
10	Various			1975	22,324	-	Various	-		22,324	10
11	Various			1976	754	-	Various	-		754	11
12	Various			1979	11,989	266	Various	266		9,080	12
13	Various			1980	37,495	1,085	Various	1,085		36,681	13
14	Various			1981	2,005	-	Various	-		2,005	14
15	Various			1982	19,747	-	Various	-		19,747	15
16	Various			1983	97,839	-	Various	-		97,839	16
17	Various			1984	5,420	-	Various	-		5,420	17
18	Various			1985	77,584	223	Various	223		76,043	18
19	Various			1986	24,379	-	Various	-		24,379	19
20	Various			1987	21,639	-	Various	-		21,639	20
21	Various			1988	10,116	-	Various	-		10,116	21
22	Various			1989	58,128	-	Various	-		58,128	22
23	Various			1990	16,116	20	Various	20		15,874	23
24	Various			1991	12,572	20	Various	20		12,310	24
25	Various			1992	22,776	167	Various	167		22,776	25
26	Various			1993	18,422	655	Various	655		17,519	26
27	Various			1994	10,251	-	Various	-		10,251	27
28	Various			1995	46,568	-	Various	-		46,568	28
29	Various			1996	18,144	-	Various	-		18,144	29
30	Various			1997	34,079	-	Various	-		34,079	30
31	Various			1998	47,371	-	Various	-		47,371	31
32	Various			1999	40,547	986	Various	986		39,314	32
33	Various			2000	916,156	22,305	Various	22,305		327,259	33
34	Various			2001	59,289	-	Various	-		59,289	34
35	Various			2002	16,745	629	Various	629		14,020	35
36	Various			2003	73,567	7,112	Various	7,112		71,839	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, 2012 Ending: June 30, 2013

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	2004	$ 31,268	$ 2,151	Various	$ 2,151	$	$ 29,684	37
38	Various	2005	51,644	4,751	Various	4,751		42,917	38
39	Various	2006	47,183	2,342	Various	2,342		33,837	39
40	Various	2007	6,145	615	Various	615		3,570	40
41	Various	2008	131,902	13,190	Various	13,190		67,759	41
42	Various	2009	258,283	20,533	Various	20,533		83,519	42
43	Various	2010	42,717	4,272	Various	4,272		13,506	43
44	300 Hall - Repaired recirculation line	3/31/2011	1,095	110	10-000	110		256	44
45	Central Dayroom - Carpet	3/31/2011	656	66	10-000	66		153	45
46	Therapy Gym - Wall Cabinets	4/14/2011	201	20	10-000	20		45	46
47	400 Hall - Skylight Roof	4/30/2011	6,250	625	10-000	625		1,406	47
48	Chaplain Office - Carpet	6/30/2011	3,298	330	10-000	330		687	48
49	100 Hall Shower Room - Whirlpool Tub	6/30/2011	8,508	851	10-000	851		1,772	49
50	100 Wing A/C Replacement	9/14/2011	2,609	261	10-000	261		478	50
51	Hot Water Heater	3/14/2012	5,188	519	10-000	519		692	51
52	SNF Plumbing	7/1/2012	5,117	256	20-000	256		256	52
53	SNF Roofing	7/1/2012	19,300	1,930	10-000	1,930		1,930	53
54	Fire Alarm System	7/1/2012	122,597	12,260	10-000	12,260		12,260	54
55	Circuit Breakers	7/1/2012	7,250	483	15-000	483		483	55
56	40x40 Garage	7/1/2012	40,468	1,619	25-000	1,619		1,619	56
57	SNF Ceiling/Drywall	7/1/2012	1,423	142	10-000	142		142	57
58	SNF Doors and Locks	7/1/2012	5,611	561	10-000	561		561	58
59	HVAC	7/1/2012	31,853	2,124	15-000	2,124		2,124	59
60	Nurse Call System	7/1/2012	2,355	235	10-000	235		235	60
61	SNF Flooring	7/1/2012	7,267	1,453	05-000	1,453		1,453	61
62	Electric Rewiring and Panels	7/1/2012	27,428	1,371	20-000	1,371		1,371	62
63	SNF Ceiling Tracks/Walls	7/1/2012	307,874	30,787	10-000	30,787		30,787	63
64	SNF Painting	7/1/2012	161,416	16,142	10-000	16,142		16,142	64
65	SNF Flooring	7/1/2012	246,763	24,676	10-000	24,676		24,676	65
66	SNF HVAC	7/1/2012	146,459	9,764	15-000	9,764		9,764	66
67	SNF Plumbing/Electric	7/1/2012	384,150	19,208	20-000	19,208		19,208	67
68	SNF Lighting/Appliances	7/1/2012	24,367	2,437	10-000	2,437		2,437	68
69	SNF Doors	7/1/2012	22,643	2,264	10-000	2,264		2,264	69
70	TOTAL (lines 4 thru 69)		$ 6,251,406	$ 269,794		$ 269,794	$	$ 2,891,902	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, 2012 Ending: June 30, 2013

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		$ 6,251,406	$ 269,794		$ 269,794	$	$ 2,891,902	1
2	SNF Cabinetry	7/1/2012	28,283	2,828	10-000	2,828		2,828	2
3	SNF Wardrobes/Cabinets	7/1/2012	148,943	14,894	10-000	14,894		14,894	3
4	SNF Doors/Hardware	7/1/2012	89,067	8,907	10-000	8,907		8,907	4
5	SNF Nurse Station	7/1/2012	87,912	5,861	15-000	5,861		5,861	5
6	SNF Ceiling Tracks/Studs	7/1/2012	289,088	28,909	10-000	28,909		28,909	6
7	SNF Flooring	7/1/2012	111,988	11,199	10-000	11,199		11,199	7
8	SNF Electrical Work/Lighting	7/1/2012	269,685	17,979	15-000	17,979		17,979	8
9	SNF Painting	7/1/2012	54,628	5,463	10-000	5,463		5,463	9
10	Fire Sprinkler	7/1/2012	434,888	17,396	25-000	17,396		17,396	10
11	IDPH Design and Plan for SNF	7/1/2012	11,736	1,174	10-000	1,174		1,174	11
12	Asbestos Survey	7/1/2012	10,465	1,047	10-000	1,047		1,047	12
13	Ceiling/Sky Lights	7/1/2012	2,685	269	10-000	269		269	13
14	Sign for Main Entrance	7/1/2012	2,248	225	10-000	225		225	14
15	Courtyard Design and Specifications	7/1/2012	5,488	549	10-000	549		549	15
16	17 Holes- Excavation	7/1/2012	2,168	217	10-000	217		217	16
17	Electrical work- main dining room	7/10/2012	1,847	185	10-000	185		185	17
18	Dementia Wing- 2 doors	7/13/2012	1,756	176	10-000	176		176	18
19	Dining Room Windows/Awning	7/18/2012	1,938	194	10-000	194		194	19
20	Electricalwork- 300 hall	7/24/2012	3,143	314	10-000	314		314	20
21	10 Ton AC Unit- 300 Hall	10/4/2012	6,922	346	15-000	346		346	21
22	400 Hall Shower Room Tub	12/27/2012	11,211	654	10-000	654		654	22
23	400 Hall Nurse's Station Electric	1/18/2013	1,751	88	10-000	88		88	23
24	Emergency Stop/Light for Generator	1/29/2013	940	24	20-000	24		24	24
25	Fire Alarm Module Installation	2/1/2013	1,072	45	10-000	45		45	25
26	Boiler Circulation Pump	2/12/2013	3,100	129	10-000	129		129	26
27	Sewer Discovery	2/13/2013	17,068	284	25-000	284		284	27
28	Sewer Mapping/Improvement	3/14/2013	277	9	10-000	9		9	28
29	Excavate and Repair Sewer Lines/Manho	6/13/2013	12,100	50	20-000	50		50	29
30	Vinyl for 400 Hall Lounge	6/14/2013	4,225	35	10-000	35		35	30
31	Carpet- 400 Wing	6/19/2013	24,847	414	05-000	414		414	31
32	Doors &Locks- 200 Hall	6/25/2013	2,243	19	10-000	19		19	32
33	SNF Casework- 400 Hall/Alz Unit	6/30/2013	38,377	320	10-000	320		320	33
34	TOTAL (lines 1 thru 33)		$ 7,933,493	$ 389,993		$ 389,993	$	$ 3,012,101	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, 2012 Ending: June 30, 2013

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 12B, Carried Forward		$ 7,933,493	$ 389,993		$ 389,993	$	$ 3,012,101	1
2	SNF Lighting & Electric- 400 Hall/Alz	6/30/2013	25,215	210	10-000	210		210	2
3	Sprinkler	6/30/2013	14,391	120	10-000	120		120	3
4	Nurse's Station maglock Doors	6/30/2013	1,305	11	10-000	11		11	4
5	Dementia Wing- 2 doors	6/30/2013	187,377	1,561	10-000	1,561		1,561	5
6	Dining Room Windows/Awning	6/30/2013	182,647	1,522	10-000	1,522		1,522	6
7	400 Hall Shower Room Tub	6/30/2013	5,315	44	10-000	44		44	7
8	400 Hall Nurse's Station Electric	6/30/2013	4,262	14	25-000	14		14	8
9	Vinyl for 400 Hall Lounge	6/30/2013	3,536	29	10-000	29		29	9
10	Add Retirements YTD Depreciation			219		219			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)		$ 8,357,542	$ 393,724		$ 393,724	$	$ 3,015,613	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, 2012 Ending: June 30, 2013

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	$ 728,720	$ 96,808	$ 96,808	$		$ 486,552	71
72	Current Year Purchases	192,818	31,430	31,430			31,430	72
73	Fully Depreciated Assets	585,005	3,401	3,401			585,006	73
74	Home Office Allocation	251,297	20,672	20,672			136,586	74
75	TOTALS	$ 1,757,840	$ 152,311	$ 152,311	$		$ 1,239,574	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	Various	$ 106,928	$ 20,142	$ 20,142	$	Various	$ 58,189	76
77										77
78										78
79	Home Office Allocation			22,590	2,565	2,565			9,088	79
80	TOTALS			$ 129,518	$ 22,707	$ 22,707	$		$ 67,277	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)	$ 10,335,129	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 568,742	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 568,742	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,322,464	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	788	87
88	Land	229,930			88
89	Apartment/Congregate	2,246,796	73,433	1,542,838	89
90	Duplex	2,274,535	60,832	1,600,504	90
91	TOTALS	$ 4,756,961	$ 134,378	$ 3,148,930	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 9,050	92
93	Home Office Allocation	146,826	93
94			94
95		$ 155,876	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, 2012 Ending: June 30, 2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 24,975 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, 2012 Ending: June 30, 2013

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 ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	5,933	$ 246,814	$	5,933	$ 246,814	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,710	89,304		1,710	89,304	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,618	250,700		6,618	250,700	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			$	14,261	$ 586,818	$	14,261	$ 586,818	14

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2013 (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	$ 4,111,788	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	665,817		3
4	Supply Inventory (priced at)	26,815		4
5	Short-Term Investments	595,773		5
6	Prepaid Insurance	11,431		6
7	Other Prepaid Expenses	13,454		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Inter/Other A/R	58,289		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,483,367	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	313,895		13
14	Buildings, at Historical Cost	12,296,218		14
15	Leasehold Improvements, at Historical Cost	288,491		15
16	Equipment, at Historical Cost	1,851,958		16
17	Accumulated Depreciation (book methods)	(7,285,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,369,764		21
22	Other Long-Term Assets (spe CIP	9,050		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,844,169	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,327,536	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 219,201	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,879		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,883		30
31	Accrued Taxes Payable (excluding real estate taxes)	649		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	18,607		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	195,026		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 717,245	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,030,450		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	647,157		43
44	Apt & Cong Life Right & Sec	555,101		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,232,708	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,949,953	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,377,583	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,327,536	$	48

***(See instructions.)**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,152,841	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,152,841	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	224,742	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)**	$ 224,742	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)**	$ 10,377,583	24	*

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	$ 6,794,065	1
2	Discounts and Allowances for all Levels	(2,087,136)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,706,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,247,093	6
7	Oxygen	9,220	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,256,313	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	33,446	13
14	Non-Patient Meals	1,767	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,492	16
17	Sale of Drugs	279,421	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58,588	19
20	Radiology and X-Ray	69,074	20
21	Other Medical Services	9,960	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 455,748	23
	D. Non-Operating Revenue		
24	Contributions	121,510	24
25	Interest and Other Investment Income***	80,025	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 201,535	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential/Congregate - See Groupings	833,488	28
28a	Unrealized Gain/Loss & Miscellaneous Income See Group	168,807	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,002,295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,622,820	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,129,724	31
32	Health Care	3,530,244	32
33	General Administration	1,888,722	33
	B. Capital Expense		
34	Ownership	740,799	34
	C. Ancillary Expense		
35	Special Cost Centers	1,108,589	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)***	$ 8,398,078	40
41	**Income before Income Taxes (line 30 minus line 40)****	224,742	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 224,742	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,063,324	44
45	Private Pay - Net Inpatient Revenue	2,888,195	45
46	Medicare - Net Inpatient Revenue	(200,867)	46
47	Other-(specify)	(43,723)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,706,929	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, 2012 Ending: June 30, 2013

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	2,178	2,178	$ 81,399	$ 37.38	1
2	Assistant Director of Nursing	1,972	2,074	62,042	29.91	2
3	Registered Nurses	9,547	10,594	271,141	25.59	3
4	Licensed Practical Nurses	32,741	35,096	761,157	21.69	4
5	CNAs & Orderlies	91,742	99,065	1,126,769	11.37	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,832	2,152	26,367	12.25	9
10	Activity Assistants	2,641	2,971	26,449	8.90	10
11	Social Service Workers	9,765	10,677	180,768	16.93	11
12	Dietician	1,910	2,078	53,270	25.64	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,845	23,121	220,698	9.55	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	7,040	7,763	100,396	12.93	17
18	Housekeepers	11,283	12,110	106,740	8.81	18
19	Laundry	4,967	5,486	50,952	9.29	19
20	Administrator	2,160	2,368	102,692	43.37	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,914	2,110	36,637	17.36	23
24	Clerical	3,760	4,010	51,422	12.82	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,572	3,982	51,291	12.88	31
32	Other Health C: MDS	2,996	3,437	89,807	26.13	32
33	Other(specify) Marketing/Apt/Co	12,942	14,529	176,820	12.17	33
34	TOTAL (lines 1 - 33)	225,804	245,800	$ 3,576,816 *	$ 14.55	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				36
37	Medical Records Consultant	104	25,333	1-3	37
38	Nurse Consultant	36	2,932	9-3	38
39	Pharmacist Consultant	144	3,660	10-3	39
40	Physical Therapy Consultant	84	2,523	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	90	4,968	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	458	$ 39,416		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, 2012 Ending: June 30, 2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Douglas Rutter	Administrator		$ 26,489
Jo Marie Silver	Administrator		24,888
Jo Hilliard	Administrator		40,501
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,878

B. Administrative - Other

Description	Amount
Management Fee	$ 472,206
TOTAL (agree to Schedule V, line 17, col. 3)	$ 472,206
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	Professional Services	$ 11,319
Davis & Campbell	Legal	22,282
Paula Perret	Legal	8,017
Heyl, Royster, Voelker & Allen	Legal	1,028
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 42,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 248,736
Unemployment Compensation Insurance	37,836
FICA Taxes	258,404
Employee Health Insurance	327,763
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	12,675
Employee Uniforms	(119)
Employee Expense	11,687
457 Plan Expense	3,125
Home Office Allocation	37,807
TOTAL (agree to Schedule V, line 22, col.8)	$ 937,914

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	26,549
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License	3,380
Dues	14,831
Subscriptions	2,275
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,035

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,636
Seminar Expense	3,787
Home Office Allocation	15,568
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,991

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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													
6													
7													
8													
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, 2012 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, $8,336.34**

(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. $ **41,809** 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. $ **261,648**
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? **v** 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. $ **1,767**

(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 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.