FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0004630

Facility Name: Christian Nursing Home

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

County: Logan

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

HFS ID Number:

Date of Initial License for Current Owners: 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, 2013 to June 30, 2014 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, LLP, 600 Washington Avenue, 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, 2013 Ending: June 30, 2014

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	17,003	15,505	4,731	37,239	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,003	15,505	4,731	37,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.09%

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 [ ] NO [ ] If YES, enter number of beds certified 112 and days of care provided 3,700

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: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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	269,391	27,542		296,933		296,933	(421)	296,512			1
2	Food Purchase		246,301		246,301		246,301	(2,352)	243,949			2
3	Housekeeping	96,446	21,976		118,422		118,422		118,422			3
4	Laundry	46,409	4,507		50,916		50,916	(10,842)	40,074			4
5	Heat and Other Utilities			167,580	167,580		167,580	404	167,984			5
6	Maintenance	87,720	10,220	96,007	193,947		193,947	5,031	198,978			6
7	Other (specify):*											7
8	TOTAL General Services	499,966	310,546	263,587	1,074,099		1,074,099	(8,180)	1,065,919			8
	B. Health Care and Programs											
9	Medical Director			28,575	28,575		28,575		28,575			9
10	Nursing and Medical Records	2,359,674	122,346	15,841	2,497,861		2,497,861		2,497,861			10
10a	Therapy		1,715	606,965	608,680		608,680		608,680			10a
11	Activities	64,986	6,007		70,993		70,993		70,993			11
12	Social Services	148,248	2,412	16,993	167,653		167,653		167,653			12
13	CNA Training											13
14	Program Transportation	24,549		5,194	29,743		29,743	(3,022)	26,721			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,597,457	132,480	673,568	3,403,505		3,403,505	(3,022)	3,400,483			16
	C. General Administration											
17	Administrative	85,390	2,460	453,396	541,246		541,246	(336,262)	204,984			17
18	Directors Fees											18
19	Professional Services			18,936	18,936		18,936	39,279	58,215			19
20	Dues, Fees, Subscriptions & Promotions			23,597	23,597		23,597		23,597			20
21	Clerical & General Office Expenses	81,872	7,708	81,245	170,825		170,825	220,972	391,797			21
22	Employee Benefits & Payroll Taxes			960,431	960,431		960,431	44,527	1,004,958			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,875	7,875		7,875	17,887	25,762			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			116,153	116,153		116,153	1,808	117,961			26
27	Other (specify):* Marketing	34,143	352	13,071	47,566		47,566	(47,566)				27
28	TOTAL General Administration	201,405	10,520	1,674,704	1,886,629		1,886,629	(59,355)	1,827,274			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,298,828	453,546	2,611,859	6,364,233		6,364,233	(70,557)	6,293,676			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, 2013 Ending: June 30, 2014

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			600,453	600,453		600,453	39,130	639,583			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,755	196,755		196,755	(107,800)	88,955			32
33	Real Estate Taxes			1,345	1,345		1,345	(1,345)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,237	26,237		26,237		26,237			35
36	Other (specify):*											36
37	**TOTAL Ownership**			824,790	824,790		824,790	(70,015)	754,775			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			286,486	286,486		286,486	(9,046)	277,440			39
40	Barber and Beauty Shops			30,601	30,601		30,601		30,601			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,694	263,694		263,694		263,694			42
43	Other (specify):* **Apt/Congregate**	154,231		389,588	543,819		543,819	(543,819)				43
44	**TOTAL Special Cost Centers**	154,231		970,369	1,124,600		1,124,600	(552,865)	571,735			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,453,059	453,546	4,407,018	8,313,623		8,313,623	(693,437)	7,620,186			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, 2013 Ending: June 30, 2014

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	(2,352)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,500)	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	(107,800)	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	(2,833)	21		24
25	Fund Raising, Advertising and Promotional	(47,566)	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	(553,706)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (715,757)		$	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)	22,320		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 22,320		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (693,437)		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, 2013

Ending: June 30, 2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (3,022)	14	1
2	Apt / Congregate	(543,819)	43	2
3	Real Estate Tax	(1,345)	33	3
4	Late Fees, Fines and Penalties	(145)	21	4
5	Miscellaneous Revenue	(4,954)	21	5
6	Vending Revenue	(421)	1	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(553,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home **#** 0004630 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 2014

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	(421)	0	0	0	0	0	0	0	0	0	0	(421)	1
2	Food Purchase	(2,352)	0	0	0	0	0	0	0	0	0	0	(2,352)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(10,842)	0	0	0	0	0	0	0	0	0	(10,842)	4
5	Heat and Other Utilities	(1,500)	1,904	0	0	0	0	0	0	0	0	0	404	5
6	Maintenance	0	5,031	0	0	0	0	0	0	0	0	0	5,031	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,273)	(3,907)	0	0	0	0	0	0	0	0	0	(8,180)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,022)	0	0	0	0	0	0	0	0	0	0	(3,022)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,022)	0	0	0	0	0	0	0	0	0	0	(3,022)	16
	C. General Administration													
17	Administrative	0	(336,262)	0	0	0	0	0	0	0	0	0	(336,262)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	39,279	0	0	0	0	0	0	0	0	0	39,279	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,932)	228,904	0	0	0	0	0	0	0	0	0	220,972	21
22	Employee Benefits & Payroll Taxes	0	44,527	0	0	0	0	0	0	0	0	0	44,527	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,887	0	0	0	0	0	0	0	0	0	17,887	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,808	0	0	0	0	0	0	0	0	0	1,808	26
27	Other (specify):*	(47,566)	0	0	0	0	0	0	0	0	0	0	(47,566)	27
28	**TOTAL General Administration**	(55,498)	(3,857)	0	0	0	0	0	0	0	0	0	(59,355)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(62,793)	(7,764)	0	0	0	0	0	0	0	0	0	(70,557)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 2014

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	39,130	0	0	0	0	0	0	0	0	0	39,130	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(107,800)	0	0	0	0	0	0	0	0	0	0	(107,800)	32
33	Real Estate Taxes	(1,345)	0	0	0	0	0	0	0	0	0	0	(1,345)	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**	(109,145)	39,130	0	0	0	0	0	0	0	0	0	(70,015)	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	(9,046)	0	0	0	0	0	0	0	0	0	(9,046)	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):*	(543,819)	0	0	0	0	0	0	0	0	0	0	(543,819)	43
44	**TOTAL Special Cost Centers**	(543,819)	(9,046)	0	0	0	0	0	0	0	0	0	(552,865)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(715,757)	22,320	0	0	0	0	0	0	0	0	0	(693,437)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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%	$ 1,904	$ 1,904	1
2	V	6	Maintenance				5,031	5,031	2
3	V	17	Administration	453,396			117,134	(336,262)	3
4	V	19	Professional Services				39,279	39,279	4
5	V	21	Clerical				228,299	228,299	5
6	V	22	Employee Benefits				44,527	44,527	6
7	V	4	Interest				(10,842)	(10,842)	7
8	V	24	Travel & Seminars				17,887	17,887	8
9	V	26	Insurance				1,808	1,808	9
10	V	30	Depreciation				39,130	39,130	10
11	V	21	Other Administrative Expense				605	605	11
12	V								12
13	V	39	Pharmacy Services	183,871			174,825	(9,046)	13
14	Total			$ 637,267			$ 659,587	$ * 22,320	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, 2013 Ending: June 30, 2014

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, 2013 Ending: June 30, 2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: ne 30, 2014

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, 2013 Ending: June 30, 2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority Series 2007		X	Refinance old debt		6/30/2007	$ 382,171	$ 770,739	6/30/2031	5.6700	$ 44,941	1
2	Illinois Finance Authority Series 2010		X	Refinance old debt		7/31/2010	2,000,000	2,008,181	5/15/2027	6.1300	118,538	2
3	Bond Fund	X		Debt Relocation	$3,314.00	***	843,874	591,839	6/30/2032	***	33,277	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,314.00		$ 3,226,045	$ 3,370,759			$ 196,756	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	$ 3,370,759			$ 196,756	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, 2013 Ending: June 30, 2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-623-005-00	See Attached	$ 337.42	$
2.	12-036-031-00	See Attached	$ 992.06	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,329.48	$

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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, 2013 Ending: June 30, 2014

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			7,476	2
3	TOTALS	42,000		$ 91,441	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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		439,755	7
8	Home Office Allocation				72,553	8,399		8,399		50,750	8
	Improvement Type**										
9	Various			1965	153,924	19,026	Various	19,026		60,378	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		9,347	12
13	Various			1980	37,495	814	Various	814		37,495	13
14	Various			1981	2,005	-	Various	-		2,005	14
15	Various			1982	19,747	-	Various	-		19,747	15
16	Various			1983	88,869	-	Various	-		88,869	16
17	Various			1984	5,420	-	Various	-		5,420	17
18	Various			1985	77,584	223	Various	223		76,266	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		15,895	23
24	Various			1991	12,572	20	Various	20		12,330	24
25	Various			1992	22,776		Various	-		22,776	25
26	Various			1993	18,422	655	Various	655		18,173	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		40,300	32
33	Various			2000	915,480	22,090	Various	22,090		348,707	33
34	Various			2001	59,289	-	Various	-		59,289	34
35	Various			2002	16,745	629	Various	629		14,649	35
36	Various			2003	73,567	1,728	Various	1,728		73,567	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, 2013 Ending: June 30, 2014

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	$ 1,584	Various	$ 1,584	$	$ 31,268	37
38	Various	2005	51,644	4,751	Various	4,751		47,668	38
39	Various	2006	47,183	2,342	Various	2,342		36,179	39
40	Various	2007	6,145	615	Various	615		4,185	40
41	Various	2008	131,902	13,190	Various	13,190		80,949	41
42	Various	2009	258,283	20,533	Various	20,533		104,051	42
43	Various	2010	42,717	4,272	Various	4,272		17,777	43
44	300 Hall - Repaired recirculation line	3/31/2011	1,095	110	10-000	110		365	44
45	Central Dayroom - Carpet	3/31/2011	656	66	10-000	66		219	45
46	Therapy Gym - Wall Cabinets	4/14/2011	201	20	10-000	20		65	46
47	400 Hall - Skylight Roof	4/30/2011	6,250	625	10-000	625		2,031	47
48	Chaplain Office - Carpet	6/30/2011	3,298	330	10-000	330		1,017	48
49	100 Hall Shower Room - Whirlpool Tub	6/30/2011	8,508	851	10-000	851		2,623	49
50	100 Wing A/C Replacement	9/14/2011	2,609	261	10-000	261		739	50
51	Hot Water Heater	3/14/2012	5,188	519	10-000	519		1,211	51
52	SNF Plumbing	7/1/2012	5,117	256	20-000	256		512	52
53	SNF Roofing	7/1/2012	19,300	1,930	10-000	1,930		3,860	53
54	Fire Alarm System	7/1/2012	122,597	12,260	10-000	12,260		24,519	54
55	Circuit Breakers	7/1/2012	7,250	483	15-000	483		967	55
56	40x40 Garage	7/1/2012	40,468	1,619	25-000	1,619		3,237	56
57	SNF Ceiling/Drywall	7/1/2012	1,423	142	10-000	142		285	57
58	SNF Doors and Locks	7/1/2012	5,611	561	10-000	561		1,122	58
59	HVAC	7/1/2012	31,853	2,124	15-000	2,124		4,247	59
60	Nurse Call System	7/1/2012	2,355	235	10-000	235		471	60
61	SNF Flooring	7/1/2012	7,267	1,453	05-000	1,453		2,907	61
62	Electric Rewiring and Panels	7/1/2012	27,428	1,371	20-000	1,371		2,743	62
63	SNF Ceiling Tracks/Walls	7/1/2012	307,874	30,787	10-000	30,787		61,575	63
64	SNF Painting	7/1/2012	161,416	16,142	10-000	16,142		32,283	64
65	SNF Flooring	7/1/2012	246,763	24,676	10-000	24,676		49,353	65
66	SNF HVAC	7/1/2012	146,459	9,764	15-000	9,764		19,528	66
67	SNF Plumbing/Electric	7/1/2012	384,150	19,208	20-000	19,208		38,415	67
68	SNF Lighting/Appliances	7/1/2012	24,367	2,437	10-000	2,437		4,873	68
69	SNF Doors	7/1/2012	22,643	2,264	10-000	2,264		4,529	69
70	TOTAL (lines 4 thru 69)		$ 6,252,936	$ 264,618		$ 264,618	$	$ 3,148,745	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, 2013 Ending: June 30, 2014

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		$ 6,252,936	$ 264,618		$ 264,618	$	$ 3,148,745	1
2	SNF Cabinetry	7/1/2012	28,283	2,828	10-000	2,828		5,657	2
3	SNF Wardrobes/Cabinets	7/1/2012	148,943	14,894	10-000	14,894		29,789	3
4	SNF Doors/Hardware	7/1/2012	89,067	8,907	10-000	8,907		17,813	4
5	SNF Nurse Station	7/1/2012	87,912	5,861	15-000	5,861		11,722	5
6	SNF Ceiling Tracks/Studs	7/1/2012	289,088	28,909	10-000	28,909		57,818	6
7	SNF Flooring	7/1/2012	111,988	11,199	10-000	11,199		22,398	7
8	SNF Electrical Work/Lighting	7/1/2012	269,685	17,979	15-000	17,979		35,958	8
9	SNF Painting	7/1/2012	54,628	5,463	10-000	5,463		10,926	9
10	Fire Sprinkler	7/1/2012	434,888	17,396	25-000	17,396		34,791	10
11	IDPH Design and Plan for SNF	7/1/2012	11,736	1,174	10-000	1,174		2,347	11
12	Asbestos Survey	7/1/2012	10,465	1,047	10-000	1,047		2,093	12
13	Ceiling/Sky Lights	7/1/2012	2,685	269	10-000	269		537	13
14	Sign for Main Entrance	7/1/2012	2,248	225	10-000	225		450	14
15	Courtyard Design and Specifications	7/1/2012	5,488	549	10-000	549		1,098	15
16	17 Holes- Excavation	7/1/2012	2,168	217	10-000	217		434	16
17	Electrical work- main dining room	7/10/2012	1,847	185	10-000	185		369	17
18	Dementia Wing- 2 doors	7/13/2012	1,756	176	10-000	176		351	18
19	Dining Room Windows/Awning	7/18/2012	1,938	194	10-000	194		388	19
20	Electricalwork- 300 hall	7/24/2012	3,143	314	10-000	314		629	20
21	10 Ton AC Unit- 300 Hall	10/4/2012	6,922	461	15-000	461		808	21
22	400 Hall Shower Room Tub	12/27/2012	11,211	1,121	10-000	1,121		1,775	22
23	400 Hall Nurse's Station Electric	1/18/2013	1,751	175	10-000	175		263	23
24	Emergency Stop/Light for Generator	1/29/2013	940	47	20-000	47		71	24
25	Fire Alarm Module Installation	2/1/2013	1,072	107	10-000	107		152	25
26	Boiler Circulation Pump	2/12/2013	3,100	310	10-000	310		439	26
27	Sewer Discovery	2/13/2013	17,068	683	25-000	683		967	27
28	Sewer Mapping/Improvement	3/14/2013	277	28	10-000	28		37	28
29	Excavate and Repair Sewer Lines/Manho	6/13/2013	12,100	605	20-000	605		655	29
30	Vinyl for 400 Hall Lounge	6/14/2013	4,225	423	10-000	423		458	30
31	Carpet- 400 Wing	6/19/2013	24,847	4,969	05-000	4,969		5,384	31
32	Doors &Locks- 200 Hall	6/25/2013	2,243	224	10-000	224		243	32
33	SNF Casework- 400 Hall/Alz Unit	6/30/2013	38,377	3,838	10-000	3,838		4,158	33
34	TOTAL (lines 1 thru 33)		$ 7,935,023	$ 395,391		$ 395,391	$	$ 3,399,718	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, 2013 Ending: June 30, 2014

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		$ 7,935,023	$ 395,391		$ 395,391	$	$ 3,399,718	1
2	SNF Lighting & Electric- 400 Hall/Alz	6/30/2013	25,215	2,522	10-000	2,522		2,732	2
3	Sprinkler	6/30/2013	14,391	1,439	10-000	1,439		1,559	3
4	Nurse's Station maglock Doors	6/30/2013	1,305	130	10-000	130		141	4
5	Dementia Wing- 2 doors	6/30/2013	187,377	18,738	10-000	18,738		20,299	5
6	Dining Room Windows/Awning	6/30/2013	182,647	18,265	10-000	18,265		19,787	6
7	400 Hall Shower Room Tub	6/30/2013	5,315	532	10-000	532		576	7
8	400 Hall Nurse's Station Electric	6/30/2013	4,262	170	25-000	170		185	8
9	Vinyl for 400 Hall Lounge	6/30/2013	3,536	354	10-000	354		383	9
10	Flooring - Oxygen Room	9/17/2013	800	67	10-000	67		67	10
11	Oxygen Room - Ceiling Replacement	9/4/2013	706	59	10-000	59		59	11
12	Oxygen Room - Exhaust Fan & Roof Curb	12/9/2013	3,451	201	10-000	201		201	12
13	Replace AC in the Kitchen	6/19/2014	17,980	150	10-000	150		150	13
14	Directional Sign & Graphics	10/23/2013	3,730	280	10-000	280		280	14
15	Asphalt paving & concrete of parking lot	6/25/2014	77,561	808	8-000	808		808	15
16	Sewer Project	3/17/2014	190,800	2,544	25-000	2,544		2,544	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)		$ 8,654,100	$ 441,649		$ 441,649	$	$ 3,449,488	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, 2013 Ending: June 30, 2014

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	$ 632,494	$ 124,882	$ 124,882	$		$ 354,371	71
72	Current Year Purchases	240,160	24,079	24,079			24,079	72
73	Fully Depreciated Assets	850,896					850,896	73
74	Home Office Allocation	286,009	27,710	27,710			170,500	74
75	TOTALS	$ 2,009,559	$ 176,671	$ 176,671	$		$ 1,399,846	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	$ 18,242	$ 18,242	$	Various	$ 76,319	76
77										77
78										78
79	Home Office Allocation			26,089	3,020	3,020			14,859	79
80	TOTALS			$ 133,017	$ 21,262	$ 21,262	$		$ 91,178	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)	$ 10,888,117	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 639,582	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 639,582	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)	$ 4,940,512	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		900	87
88	Land	229,930			88
89	Apartment/Congregate	2,268,947	72,837	1,607,785	89
90	Duplex	2,272,016	63,787	1,634,091	90
91	TOTALS	$ 4,776,593	$ 136,624	$ 3,247,576	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 9,050	92
93	Home Office Allocation	111	93
94			94
95		$ 9,161	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, 2013 Ending: June 30, 2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 26,237 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, 2013 Ending: June 30, 2014

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.

   TCVonly 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, 2013 Ending: June 30, 2014

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	$	6,973	$ 249,235	$	6,973	$ 249,235	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,937	101,235		1,937	101,235	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,804	256,495		6,804	256,495	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			$	15,714	$ 606,965	$	15,714	$ 606,965	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, 2013 Ending: June 30, 2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2014 (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	$ 4,002,577	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 23,286)	1,000,937		3
4	Supply Inventory (priced at)	15,758		4
5	Short-Term Investments	638,132		5
6	Prepaid Insurance	11,647		6
7	Other Prepaid Expenses	20,559		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int. / Other A/R	11,138		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,700,748	$	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	12,316,516		14
15	Leasehold Improvements, at Historical Cost	560,582		15
16	Equipment, at Historical Cost	2,081,591		16
17	Accumulated Depreciation (book methods)	(7,951,980)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,716,354		21
22	Other Long-Term Assets (spe CIP	17,750		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,054,708	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,755,456	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 194,050	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,275		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	243,066		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	665		32
33	Accrued Interest Payable	21,408		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	138,240		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 635,704	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,370,759		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	539,737		43
44	Apt & Cong Life Right & Sec	382,608		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,293,104	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,928,808	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,826,648	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,755,456	$	48

*(See instructions.)

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,377,583	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,377,583	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	449,065	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)**	$ 449,065	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)**	$ 10,826,648	24 *

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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	$ 6,901,110	1
2	Discounts and Allowances for all Levels	(2,334,121)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,566,989	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,393,821	6
7	Oxygen	1,447	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,395,268	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	30,675	13
14	Non-Patient Meals	2,352	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,500	16
17	Sale of Drugs	245,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,753	19
20	Radiology and X-Ray	83,196	20
21	Other Medical Services	11,203	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 428,880	23
	D. Non-Operating Revenue		
24	Contributions	173,430	24
25	Interest and Other Investment Income***	107,800	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 281,230	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center	800,020	28
28a	Miscellaneous	290,301	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,090,321	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,762,688	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,074,099	31
32	Health Care	3,403,505	32
33	General Administration	1,886,629	33
	B. Capital Expense		
34	Ownership	824,790	34
	C. Ancillary Expense		
35	Special Cost Centers	1,124,600	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)***	$ 8,313,623	40
41	**Income before Income Taxes (line 30 minus line 40)****	449,065	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 449,065	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,099,409	44
45	Private Pay - Net Inpatient Revenue	2,843,217	45
46	Medicare - Net Inpatient Revenue	(363,909)	46
47	Other-(specify) HMO/Outpatient Part B	(11,728)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,566,989	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, 2013 Ending: June 30, 2014

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	1,980	2,080	$ 82,916	$ 39.86	1
2	Assistant Director of Nursing	1,924	2,080	67,122	32.27	2
3	Registered Nurses	9,696	10,271	279,205	27.18	3
4	Licensed Practical Nurses	33,698	35,755	700,670	19.60	4
5	CNAs & Orderlies	89,733	96,005	1,083,609	11.29	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	2,051	2,221	29,686	13.37	9
10	Activity Assistants	3,639	3,784	35,300	9.33	10
11	Social Service Workers	8,715	9,534	172,797	18.12	11
12	Dietician	1,960	2,080	54,147	26.03	12
13	Food Service Supervisor	-	-	-		13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	21,385	22,840	215,244	9.42	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	5,482	5,808	87,720	15.10	17
18	Housekeepers	9,984	10,892	96,446	8.85	18
19	Laundry	4,893	5,004	46,423	9.28	19
20	Administrator	1,917	2,089	84,197	40.31	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	3,608	4,047	63,553	15.71	23
24	Clerical	2,093	2,391	33,324	13.94	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	2,665	2,902	40,067	13.81	31
32	Other Health Care(specify)	3,416	4,054	106,070	26.16	32
33	Other(specify)	12,291	13,036	174,562	13.39	33
34	TOTAL (lines 1 - 33)	221,128	236,873	$ 3,453,059 *	$ 14.58	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	144	28,575		36
37	Medical Records Consultant	70	2,824		37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	3,248		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	76	4,936		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	434	$ 39,583		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, 2013 Ending: June 30, 2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jo Hilliard	Administrator	0	$ 85,390
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,390

B. Administrative - Other

Description	Amount
Management Fee	$ 453,396
TOTAL (agree to Schedule V, line 17, col. 3)	$ 453,396
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	Employee Surveys	$ 359
National Research	Employee Surveys	1,455
Cincinnati Insurance	Legal	1,789
Davis & Campbell	Legal	14,324
Heyl, Royster, Voelker	Legal	(87)
Polsinelli Shughart, PC	Legal	1,096
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 18,936

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 268,457
Unemployment Compensation Insurance	49,168
FICA Taxes	252,253
Employee Health Insurance	368,790
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	8,675
Employee Uniforms	(339)
Employee Expense	9,177
457 Plan Expense	4,250
Home Office Allocation	44,527
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,004,958

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	(1,182)
Health Care Worker Background Check	
(Indicate # of checks performed 35)	936
Patient Background Checks 105	1,050
License	2,282
Dues	19,551
Subscriptions	960
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,597

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,132
In-State Travel	1,511
Seminar Expense	4,232
Home Office Allocation	17,887
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,762

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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, 2013 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 $8,707**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,673** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **263,694**
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? **N** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,352**

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