FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: Kenna Hudson **Telephone Number:** 314-587-7924
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/17 to 6/30/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Chuck Schmitz
(Title) CFO

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,260	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	124	TOTALS	124	45,260	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	17,585	15,992	5,376	38,953	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,585	15,992	5,376	38,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.06%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, Lawn & Maint Care, Housekeeping & Laundry Services for 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 9/1/1995

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 _____ and days of care provided 4,089

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: 6/30/18 Fiscal Year: 6/30/18

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,545	25,642	4,497	304,684		304,684		304,684			1
2	Food Purchase		245,276		245,276		245,276		245,276			2
3	Housekeeping	151,540		26,222	177,762		177,762		177,762			3
4	Laundry	26,791		489	27,280		27,280		27,280			4
5	Heat and Other Utilities			174,465	174,465		174,465	1,762	176,227			5
6	Maintenance	65,346	108,301		173,647		173,647	3,646	177,293			6
7	Other (specify):* Trash			10,627	10,627		10,627		10,627			7
8	TOTAL General Services	518,222	379,219	216,300	1,113,741		1,113,741	5,408	1,119,149			8
	B. Health Care and Programs											
9	Medical Director			44,400	44,400		44,400		44,400			9
10	Nursing and Medical Records	3,039,424	106,485	19,587	3,165,496		3,165,496		3,165,496			10
10a	Therapy			779,795	779,795		779,795		779,795			10a
11	Activities	93,745	7,204		100,949		100,949		100,949			11
12	Social Services	191,936		12,795	204,731		204,731		204,731			12
13	CNA Training											13
14	Program Transportation			20,486	20,486		20,486		20,486			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,325,105	113,689	877,063	4,315,857		4,315,857		4,315,857			16
	C. General Administration											
17	Administrative	107,697		538,404	646,101		646,101	(509,240)	136,861			17
18	Directors Fees											18
19	Professional Services			33,211	33,211		33,211	64,361	97,572			19
20	Dues, Fees, Subscriptions & Promotions			38,160	38,160		38,160	(1,512)	36,648			20
21	Clerical & General Office Expenses	156,090	53,764	422,296	632,150		632,150	23,238	655,388			21
22	Employee Benefits & Payroll Taxes			858,095	858,095		858,095	89,245	947,340			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,944	14,944		14,944	38,110	53,054			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			178,294	178,294		178,294	1,034	179,328			26
27	Other (specify):* Marketing	93,179		45,432	138,611		138,611	(138,611)				27
28	TOTAL General Administration	356,966	53,764	2,128,836	2,539,566		2,539,566	(433,375)	2,106,191			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,200,293	546,672	3,222,199	7,969,164		7,969,164	(427,967)	7,541,197			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: 7/1/17 Ending: 6/30/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			712,794	712,794		712,794	37,725	750,519			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,167	91,167		91,167		91,167			32
33	Real Estate Taxes			1,232	1,232		1,232		1,232			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,491	5,491		5,491		5,491			35
36	Other (specify):*			1,318	1,318		1,318		1,318			36
37	**TOTAL Ownership**			812,002	812,002		812,002	37,725	849,727			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,749	316,396	327,145		327,145	(16,955)	310,190			39
40	Barber and Beauty Shops			3,982	3,982		3,982		3,982			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,770	279,770		279,770		279,770			42
43	Other (specify):* AL/Apt/Duplex	456,300		927,922	1,384,222		1,384,222	(1,284,701)	99,521			43
44	**TOTAL Special Cost Centers**	456,300	10,749	1,528,070	1,995,119		1,995,119	(1,301,656)	693,463			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,656,593	557,421	5,562,271	10,776,285		10,776,285	(1,691,898)	9,084,387			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: 7/1/17 Ending: 6/30/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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				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	(26,113)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(311,305)	21		24
25	Fund Raising, Advertising and Promotional	(138,611)	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	(1,389,838)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,865,867)		$	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)	173,969	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 173,969		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,691,898)		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: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ (1,384,222)	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Lobbying	(1,512)	20	3
4	Travel and Seminanrs	(4,104)	24	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(1,389,838)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,762	0	0	0	0	0	0	0	0	0	1,762	5
6	Maintenance	0	3,646	0	0	0	0	0	0	0	0	0	3,646	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	5,408	0	0	0	0	0	0	0	0	0	5,408	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(509,240)	0	0	0	0	0	0	0	0	0	(509,240)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	64,361	0	0	0	0	0	0	0	0	0	64,361	19
20	Fees, Subscriptions & Promotions	(1,512)	0	0	0	0	0	0	0	0	0	0	(1,512)	20
21	Clerical & General Office Expenses	(337,418)	360,656	0	0	0	0	0	0	0	0	0	23,238	21
22	Employee Benefits & Payroll Taxes	0	89,245	0	0	0	0	0	0	0	0	0	89,245	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,104)	42,214	0	0	0	0	0	0	0	0	0	38,110	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	1,034	0	0	0	0	0	0	0	0	0	1,034	26
27	Other (specify):*	(138,611)	0	0	0	0	0	0	0	0	0	0	(138,611)	27
28	**TOTAL General Administration**	(481,645)	48,270	0	0	0	0	0	0	0	0	0	(433,375)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(481,645)	53,678	0	0	0	0	0	0	0	0	0	(427,967)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** 7/1/17 **Ending:** 6/30/18

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	37,725	0	0	0	0	0	0	0	0	0	37,725	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	37,725	0	0	0	0	0	0	0	0	0	37,725	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	(16,955)	0	0	0	0	0	0	0	0	0	(16,955)	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):*	(1,384,222)	99,521	0	0	0	0	0	0	0	0	0	(1,284,701)	43
44	**TOTAL Special Cost Centers**	(1,384,222)	82,566	0	0	0	0	0	0	0	0	0	(1,301,656)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,865,867)	173,969	0	0	0	0	0	0	0	0	0	(1,691,898)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Horizons	100.00%	$ 1,762	$ 1,762	1
2	V	6	Maintenance				3,646	3,646	2
3	V	17	Administrative	614,329			105,089	(509,240)	3
4	V	19	Professional Services				64,361	64,361	4
5	V	21	Clerical				314,379	314,379	5
6	V	22	Employee Benefits				89,245	89,245	6
7	V	21	Dues & Subscriptions				10,494	10,494	7
8	V	24	Travel and Seminars				42,214	42,214	8
9	V	26	Insurance				1,034	1,034	9
10	V	30	Depreciation				37,725	37,725	10
11	V	21	Other Administrative Expense				35,783	35,783	11
12	V	43	Independent Living				99,521	99,521	12
13	V	39	Pharmacy Services	273,892	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	256,937	(16,955)	13
14	Total			$ 888,221			$ 1,062,190	$ * 173,969	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: 7/1/17 Ending: 6/30/18

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	This workpaper is N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
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25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Debt		6/30/07	$ 382,171	$ 740,144	6/30/31	5.6700	$ 19,151	1
2	Illinois Finance Authority Series 2010		X	Refinance Debt		7/31/10	2,000,000	915,210	5/15/27	6.1300	25,225	2
3	Bond Fund	X		Debt Relocation	Various	Various	843,874	400,342	6/30/32	Various	9,245	3
4	Illinois Finance Authority Series 2016		X	Refinance Debt		3/1/16	2,780,395	6,353,674	5/15/40	5.0000	123,379	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,006,440	$ 8,409,370			$ 176,999	9
	B. Non-Facility Related*											
10	Interst Income Offset										(85,832)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (85,832)	14
15	TOTALS (line 9+line14)						$ 6,006,440	$ 8,409,370			$ 91,167	15

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

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 314-587-7916

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-036-031-00	See Attached Tax Bills	$ 1,129.96	$
2.	12-623-005-00	See Attached Tax Bills	$ 339.28	$
3.	12-036-032-00	See Attached Tax Bills	$ 298.96	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,768.20	$

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 7/1/17 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,353 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
AL Villa

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	43,560		$ 83,965	1
2	Home Office Allocation			7,984	2
3	TOTALS	43,560		$ 91,949	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	74		1965	1965	$ 554,625	$	54	$	$	$ 554,625	4
5	26		1972	1972	318,878		47			318,878	5
6	24		2000	2000	1,279,292	31,982	40	31,982		567,686	6
7			2016	2016	4,191,053	104,776	40	104,776		192,090	7
8	Home Office Allocation				77,717	2,719		2,719		63,856	8
	Improvement Type**										
9	Various			1965	153,924	19,026	Various	19,026		136,482	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		10,413	12
13	Various			1980	36,891		Various			36,891	13
14	Various			1982	2,875		Various			2,875	14
15	Various			1983	51,143		Various			51,143	15
16	Various			1985	7,800	223	Various	223		7,373	16
17	Various			1986	341		Various			341	17
18	Various			1987	626		Various			626	18
19	Various			1988	3,966		Various			3,966	19
20	Various			1989	475		Various			475	20
21	Various			1991	711	20	Various	20		550	21
22	Various			1992	16,457		Various			16,457	22
23	Various			1993	18,422		Various			18,422	23
24	Various			1994	2,170		Various			2,170	24
25	Various			1995	35,562		Various			35,562	25
26	Various			1996	3,400		Various			3,400	26
27	Various			1998	6,993		Various			6,993	27
28	Various			2000	898,348	22,015	Various	22,015		420,038	28
29	Various			2001	47,818		Various			47,818	29
30	Various			2002	14,534	158	Various	158		14,482	30
31	Various			2003	58,491		Various			58,491	31
32	Various			2004	2,564		Various			2,564	32
33	Various			2005	15,935		Various			15,935	33
34	Various			2006	37,276	1,255	Various	1,255		34,183	34
35	Various			2007	6,145	67	Various	67		6,095	35
36	Various			2008	111,502	10,261	Various	10,261		110,381	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: 7/1/17 Ending: 6/30/18

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	2009	$ 258,283	$ 19,824	Various	$ 19,824	$	$ 183,289	37
38	Various	2010	40,492	4,253	Various	4,253		33,159	38
39	Various	2011	8,859	1,189	Various	1,189		6,287	39
40	Hot Water Heater	2012	5,188	519	10	519		3,286	40
41	SNF Plumbing	2012	5,117	256	20	256		1,535	41
42	SNF Roofing	2012	19,300	1,930	10	1,930		11,580	42
43	Fire Alarm System	2012	98,624	9,862	10	9,862		59,172	43
44	Circuit Breakers	2012	7,250	483	15	483		2,900	44
45	40x40 Garage	2012	20,234	809	25	809		4,856	45
46	SNF Doors and Locks	2012	5,611	561	10	561		3,367	46
47	HVAC	2012	30,910	2,061	15	2,061		12,350	47
48	SNF Flooring	2012	7,267		5			7,148	48
49	Electric Rewiring and Panels	2012	27,428	1,371	20	1,371		8,228	49
50	SNF Ceiling Tracks/Walls	2012	307,874	30,787	10	30,787		184,724	50
51	SNF Painting	2012	161,416	16,142	10	16,142		96,850	51
52	SNF Flooring	2012	246,763	24,676	10	24,676		148,058	52
53	SNF HVAC	2012	146,459	9,764	15	9,764		58,584	53
54	SNF Plumbing/Electric	2012	384,150	19,208	20	19,208		115,245	54
55	SNF Lighting/Appliances	2012	24,367	2,437	10	2,437		14,620	55
56	SNF Doors	2012	22,643	2,264	10	2,264		13,586	56
57	SNF Cabinetry	2012	28,283	2,828	10	2,828		16,970	57
58	SNF Wardrobes/Cabinets	2012	148,943	14,894	10	14,894		89,366	58
59	SNF Doors/Hardware	2012	89,067	8,907	10	8,907		53,440	59
60	SNF Nurse Station	2012	87,912	5,861	15	5,861		35,165	60
61	SNF Ceiling Tracks/Studs	2012	289,088	28,909	10	28,909		173,453	61
62	SNF Flooring	2012	111,988	11,199	10	11,199		67,193	62
63	SNF Electrical Work/Lighting	2012	269,685	17,979	15	17,979		107,874	63
64	SNF Painting	2012	54,628	5,463	10	5,463		32,777	64
65	Fire Sprinkler	2012	434,888	17,396	25	17,396		104,373	65
66	IDPH Design and Plan for SNF	2012	11,736	1,174	10	1,174		7,042	66
67	Asbestos Survey	2012	10,465	1,047	10	1,047		6,279	67
68	Ceiling/Sky Lights	2012	2,685	269	10	269		1,611	68
69	Courtyard Design and Specifications	2012	5,488	549	10	549		3,293	69
70	TOTAL (lines 4 thru 69)		$ 11,364,092	$ 457,639		$ 457,639	$	$ 4,431,999	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: 7/1/17 Ending: 6/30/18

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		$ 11,364,092	$ 457,639		$ 457,639	$	$ 4,431,999	1
2	Electricalwork- 300 hall	2012	3,143	314	10	314		1,886	2
3	10 Ton AC Unit- 300 Hall	2012	6,922	461	15	461		2,654	3
4	400 Hall Shower Room Tub	2012	11,211	1,121	10	1,121		6,259	4
5	Boiler Circulation Pump	2013	3,100	310	10	310		1,679	5
6	SNF 400 Hall/Alz Unit	2013	282,149	28,215	10	28,215		144,864	6
7	Sprinkler	2013	4,262	170	25	170		867	7
8	Nurse's Station Maglock Doors	2013	3,536	354	10	354		1,798	8
9	Vinyl for 400 Hall Lounge	2013	4,225	423	10	423		2,148	9
10	Carpet- 400 Wing	2013		4,148	5	4,148		(407)	10
11	Oxygen Room- Exhaust Fan & Roof Curb	2013	3,451	345	10	345		1,582	11
12	Sewer Discovery	2013	17,068	683	25	683		3,698	12
13	Excavate and Repair Sewer Lines/Manhol	2013	12,100	605	20	605		3,075	13
14	Directional Sign & Graphics	2013	3,730	373	10	373		1,772	14
15	Replace AC in the kitchen	2014	17,980	1,798	10	1,798		7,342	15
16	Whirlpool door	2014	2,805	280	10	280		1,005	16
17	Asphalt paving & concrete of parking l	2014	77,561	9,695	8	9,695		39,588	17
18	Sewer Project	2014	189,600	7,584	25	7,584		32,864	18
19	Hydraulic sink install @ beauty shop	2015	3,564	356	10	356		1,188	19
20	Install Emergency door	2015	9,993	999	10	999		3,248	20
21	Emergency Exit bar	2015	2,123	212	10	212		690	21
22	Replace resident garage door	2015	522	52	10	52		165	22
23	Sump Pump	2015	562	56	10	56		164	23
24	New Rubber roof 40x30 section	2015	5,900	590	10	590		1,623	24
25	New Service hall double doors	2015	4,287	429	10	429		1,180	25
26	Install new roof Building 7	2015	10,875	1,088	10	1,088		2,991	26
27	Replace Mixing valve @ Memory care	2016	2,624	262	10	262		634	27
28	Therapy Room West Door	2016	4,049	405	10	405		979	28
29	400 Wing Trane AC unit	2016	6,875	688	10	688		1,490	29
30	200 Wing Heil 3 ton AC condensing unit	2016	2,681	268	10	268		581	30
31	200 Wing Heil 4 ton 3 phase AC unit	2016	4,284	428	10	428		928	31
32	Privacy Fence project at TCV	2016	84,965	4,248	20	4,248		8,497	32
33	Brick Memorial Walkway	2016	4,067	203	20	203		407	33
34	TOTAL (lines 1 thru 33)		$ 12,154,306	$ 524,802		$ 524,802	$	$ 4,709,438	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: 7/1/17 Ending: 6/30/18

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		$ 12,154,306	$ 524,802		$ 524,802	$	$ 4,709,438	1
2	5 Ton HVAC unit	2016	2,340	234	10	234		468	2
3	STS SNF Landscaping	2016	12,104	605	20	605		1,110	3
4	500 Hall Egress exit doors delay	2016	3,402	340	10	340		595	4
5	North West Kitchen Door	2017	2,744	274	10	274		366	5
6	North East Kitchen Door	2017	2,744	274	10	274		366	6
7	Install Water filtration system	2017	1,695	169	10	169		212	7
8	Door Latching Bolts	2017	1,225	123	10	123		153	8
9	Otis Passenger Elevator	2017	107,676	5,384	20	5,384		6,730	9
10	Memory Care Unit 2' Wood Blinds	2017	1,918	192	10	192		240	10
11	GP Rhab Court Yard & Parking lot concret	2017	9,428	472	20	472		589	11
12	SNF Unit 205 Rubber Roof	2017	4,889	489	10	489		570	12
13	Gravel Parking lot near Maint. garage	2017	11,330	567	20	567		661	13
14	Memory Care Roof Build 200 & 400	2017	28,855	2,886	10	2,886		3,366	14
15	Memory Care Unit New Flooring	2017	45,234	4,523	10	4,523		4,900	15
16	Memory Care Nurse Sta. Counter	2017	2,194	219	10	219		238	16
17	Main Dining Solar Shades & Valances	2017	8,308	1,662	5	1,662		1,662	17
18	Memory Care Roof 200	2017	46,700	4,670	10	4,670		4,670	18
19	Memory Care Unit Wood Blinds (18)	2017	2,799	400	7	400		400	19
20	Memory Care Unit Doors (3)	2017	545	71	7	71		71	20
21	Replace Maple Trees (6)	2017	2,473	93	20	93		93	21
22	New Flooring in common room area	2017	7,817	521	10	521		521	22
23	Fire Sprinkler System upgrade piping	2017	5,690	474	7	474		474	23
24	Gas Water Heater 100gl	2017	5,725	334	10	334		334	24
25	Refinish SNF Residents Doors	2018	11,263	375	10	375		375	25
26	Rounding		1	5		5		(3)	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,483,405	$ 550,158		$ 550,158	$	$ 4,738,599	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: 7/1/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,277,207	$ 150,799	$ 150,799	$		$ 942,091	71
72	Current Year Purchases	76,415	13,628	13,628			13,628	72
73	Fully Depreciated Assets	479,651	928	928			479,651	73
74	Home Office Allocation	203,827	33,107	33,107			151,760	74
75	TOTALS	$ 2,037,100	$ 198,462	$ 198,462	$		$ 1,587,130	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	2009 Tomberlin E4 Golf Cart		2009	$ 8,850	$	$	$	4	$ 8,850	76
77	2009 Ford Starcraft bus		2009	48,290				8	47,795	77
78	2011 Dodge Grand Caravan Express - White		2011	41,548				4	41,548	78
79	Home Office Allocation			11,469	6,377	6,377			10,400	79
80	TOTALS			$ 110,157	$ 6,377	$ 6,377	$		$ 108,593	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)	$ 14,722,611	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 754,997	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 754,997	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)	$ 6,434,322	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	238,843			88
89	Garden Villa	1,397,801	46,923	97,466	89
90	Apartment/Congregate/Duplex	5,087,464	190,812	3,615,405	90
91	TOTALS	$ 6,729,808	$ 237,735	$ 3,718,571	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 64,705	92
93	Home Office Allocation	45,595	93
94			94
95		$ 110,300	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: 7/1/17 Ending: 6/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 19,871 Description: ____
(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: 7/1/17 Ending: 6/30/18

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.

   TCV only hires certified CNAs

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	hrs	$	6,282	$ 329,659	$	6,282	$ 329,659	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		2,238	96,128		2,238	96,128	2
3	Licensed Recreational Therapist	V10A	hrs		0	0				3
4	Licensed Physical Therapist	V10A	hrs		8,063	354,007		8,063	354,007	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				242,077		242,077	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					41,027		41,027	12
13	Other (specify): BILLABLE SUPPLIES	V39					44,040		44,040	13
14	TOTAL			$	16,583	$ 779,794	$ 327,144	16,583	$ 1,106,938	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: 7/1/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/18 (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	$ 7,078	$	1
2	Cash-Patient Deposits	19,890		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 345,387)	799,325		3
4	Supply Inventory (priced at)	15,745		4
5	Short-Term Investments	3,839,599		5
6	Prepaid Insurance	733		6
7	Other Prepaid Expenses	23,806		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int Rec/AR Other	41,200		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,747,376	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	322,808		13
14	Buildings, at Historical Cost	18,837,212		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,991,402		16
17	Accumulated Depreciation (book methods)	(9,926,877)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	272,016		21
22	Other Long-Term Assets (spe CIP	64,705		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,561,266	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,308,642	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (4,581,486)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,890		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,349		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	50,756		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Liabilities	339,129		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (3,834,362)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,409,371		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	236,148		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,645,519	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,811,157	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,497,485	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,308,642	$	48

***(See instructions.)**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,086,759	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,086,759	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(582,139)	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) **Temp Restricted Activity**	(7,135)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (589,274)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	(0)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (0)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,497,485	24 *

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 9,184,917	1
2	Discounts and Allowances for all Levels	(5,975,587)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,209,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,875,713	6
7	Oxygen	2,047	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,877,760	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	370,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,072	19
20	Radiology and X-Ray	33,307	20
21	Other Medical Services	63,167	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 512,938	23
	D. Non-Operating Revenue		
24	Contributions	139,524	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 139,524	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	1,366,268	28
28a	Misc Revenue	88,325	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,454,593	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,194,145	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,113,741	31
32	Health Care	4,276,437	32
33	General Administration	2,578,986	33
	B. Capital Expense		
34	Ownership	812,002	34
	C. Ancillary Expense		
35	Special Cost Centers	1,715,348	35
36	Provider Participation Fee	279,770	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,776,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	(582,139)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (582,139)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,071,743	44
45	Private Pay - Net Inpatient Revenue	2,561,723	45
46	Medicare - Net Inpatient Revenue	(823,458)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(314,452)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,286,226)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,209,330	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: 7/1/17 Ending: 6/30/18

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	1,977	2,144	$ 104,012	$ 48.51	1
2	Assistant Director of Nursing	1,432	1,504	50,432	33.53	2
3	Registered Nurses	8,066	8,280	436,059	52.66	3
4	Licensed Practical Nurses	36,572	38,803	823,532	21.22	4
5	CNAs & Orderlies	93,455	106,248	1,553,291	14.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,852	2,033	29,069	14.30	9
10	Activity Assistants	6,327	6,504	64,778	9.96	10
11	Social Service Workers	7,990	8,447	191,836	22.71	11
12	Dietician					12
13	Food Service Supervisor	1,476	1,699	46,794	27.54	13
14	Head Cook	4,437	4,813	53,520	11.12	14
15	Cook Helpers/Assistants	16,702	17,410	174,231	10.01	15
16	Dishwashers					16
17	Maintenance Workers	3,578	3,767	65,346	17.35	17
18	Housekeepers	12,461	13,337	151,540	11.36	18
19	Laundry	2,209	2,360	26,791	11.35	19
20	Administrator	1,790	1,854	107,697	58.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,520	5,792	195,510	33.76	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	1,860	2,022	32,675	16.16	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) Marketing/AL/IL	36,398	39,332	549,480	13.97	33
34	TOTAL (lines 1 - 33)	244,102	266,349	$ 4,656,593 *	$ 17.48	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	22	$ 1,373	V01-3	35
36	Medical Director	216	44,400	V09-3	36
37	Medical Records Consultant	32	2,488	V10-3	37
38	Nurse Consultant	38	1,501	V10-3	38
39	Pharmacist Consultant	144	3,342	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	73	4,099	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	525	$ 57,203		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13	$ 616	V10-3	50
51	Licensed Practical Nurses	155	6,110	V10-3	51
52	Certified Nurse Assistants/Aides	21	519	V10-3	52
53	TOTAL (lines 50 - 52)	189	$ 7,245		53

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jo Hilliard	Administrator	0	$ 46,211
Steven Territo	Administrator	0	61,486
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,697

B. Administrative - Other

Description	Amount
Management Fee	$ 538,404
TOTAL (agree to Schedule V, line 17, col. 3)	$ 538,404
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 2,608
Davis & Campbell	Legal	8,977
Delaney, Delaney & Voorn	Legal	251
Polsinelli Shughart	Legal	21,375
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 33,211

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,884
Unemployment Compensation Insurance	2,820
FICA Taxes	309,789
Employee Health Insurance	405,833
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
457 Plan Expense	1,925
Newe Hire Expense	24,997
Employee Uniforms	(98)
Employee Expense	30,945
TOTAL (agree to Schedule V, line 22, col.8)	$ 947,340

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 180	1,800
License	1,379
Dues	16,231
Subscription	17,238
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,648

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,590
In-State Travel	6,328
Seminar Expense	3,026
Non Allowable Marketing Adj	(4,104)
Home Office Allocation	42,214
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 53,054

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/17 Ending: 6/30/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LEADING AGE- $10,801**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,933** 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. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **279,770**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,642**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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. $ **N/A**

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

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