

Facility Name & ID Number Christian Nursing Home# 0004630 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</u>	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	<u>112</u>	TOTALS	<u>112</u>	<u>40,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
8	SNF	<u>14,456</u>	<u>19,077</u>	<u>4,388</u>	<u>37,921</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,456</u>	<u>19,077</u>	<u>4,388</u>	<u>37,921</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.76%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)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started 09/01/1995J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO 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 2,865Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

STATE OF ILLINOIS

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Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	176,284	33,359	8,506	218,149		218,149		218,149		1
2	Food Purchase		209,527		209,527		209,527	(2,049)	207,478		2
3	Housekeeping	169,484	31,693		201,177		201,177		201,177		3
4	Laundry										4
5	Heat and Other Utilities			131,848	131,848		131,848	5,812	137,660		5
6	Maintenance	82,974	31,325	45,042	159,341		159,341	8,629	167,970		6
7	Other (specify):* Trash Removal			6,109	6,109		6,109		6,109		7
8	TOTAL General Services	428,742	305,904	191,505	926,151		926,151	12,392	938,543		8
	B. Health Care and Programs										
9	Medical Director			2,300	2,300		2,300		2,300		9
10	Nursing and Medical Records	1,839,783	194,344	30,331	2,064,458		2,064,458		2,064,458		10
10a	Therapy			174,855	174,855		174,855		174,855		10a
11	Activities	8,053			8,053		8,053	231	8,284		11
12	Social Services	138,391	3,617	5,584	147,592		147,592		147,592		12
13	CNA Training										13
14	Program Transportation			2,480	2,480		2,480	(4,661)	(2,181)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,986,227	197,961	215,550	2,399,738		2,399,738	(4,430)	2,395,308		16
	C. General Administration										
17	Administrative	202,769	3,182	312,168	518,119		518,119	(247,301)	270,818		17
18	Directors Fees										18
19	Professional Services			3,397	3,397		3,397	14,730	18,127		19
20	Dues, Fees, Subscriptions & Promotions			57,057	57,057		57,057	(16,230)	40,827		20
21	Clerical & General Office Expenses	139,085	10,840	42,351	192,276		192,276	39,364	231,640		21
22	Employee Benefits & Payroll Taxes			555,448	555,448		555,448	19,007	574,455		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,824	9,824		9,824	12,042	21,866		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			87,805	87,805		87,805	2,325	90,130		26
27	Other (specify):*										27
28	TOTAL General Administration	341,854	14,022	1,068,050	1,423,926		1,423,926	(176,063)	1,247,863		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,756,823	517,887	1,475,105	4,749,815		4,749,815	(168,101)	4,581,714		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, 2005

Ending:

June 30, 2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			225,668	225,668		225,668	23,982	249,650			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,603	53,603		53,603	(57,484)	(3,881)			32
33	Real Estate Taxes			1,080	1,080		1,080		1,080			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,128	1,128		1,128		1,128			36
37	TOTAL Ownership			281,479	281,479		281,479	(33,502)	247,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			21,176	21,176		21,176		21,176			39
40	Barber and Beauty Shops			26,839	26,839		26,839		26,839			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,314	61,314		61,314		61,314			42
43	Other (specify):*			454,428	454,428		454,428	(454,428)				43
44	TOTAL Special Cost Centers			563,757	563,757		563,757	(454,428)	109,329			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,756,823	517,887	2,320,341	5,595,051		5,595,051	(656,031)	4,939,020			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, 2005

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(918)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,223)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,739	30		9
10	Interest and Other Investment Income	(134,016)	32		10
11	Discounts, Allowances, Rebates & Refunds	(887)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,374)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,821)	21		24
25	Fund Raising, Advertising and Promotional	(16,230)	20		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	(447,772)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (603,502)		\$	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	2	
		Amount	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)	(52,529)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (52,529)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (656,031)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ (1,131)	2	1
2	Activity	231	11	2
3	Exempt Interest Income - Endowment	78,634	32	3
4	Miscellaneous	(350)	17	4
5	Transportation	(4,661)	14	5
6	Late Fees	(203)	6	6
7	Late Fees	(91)	21	7
8	Marketing Salaries	(62,925)	21	8
9	Marketing Other Expenses	(2,848)	21	9
10	Apt/Congregate	(454,428)	43	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	(447,772)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

July 1, 2005

Ending:

June 30, 2006

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	(2,049)	0	0	0	0	0	0	0	0	0	0	(2,049)	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	(1,223)	7,035	0	0	0	0	0	0	0	0	0	5,812	5
6	Maintenance	(203)	8,832	0	0	0	0	0	0	0	0	0	8,629	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,475)	15,867	0	12,392	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	231	0	0	0	0	0	0	0	0	0	0	231	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,661)	0	0	0	0	0	0	0	0	0	0	(4,661)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,430)	0	0	0	0	0	0	0	0	0	0	(4,430)	16
	C. General Administration													
17	Administrative	(350)	(246,951)	0	0	0	0	0	0	0	0	0	(247,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,730	0	0	0	0	0	0	0	0	0	14,730	19
20	Fees, Subscriptions & Promotions	(16,230)	0	0	0	0	0	0	0	0	0	0	(16,230)	20
21	Clerical & General Office Expenses	(70,572)	109,936	0	0	0	0	0	0	0	0	0	39,364	21
22	Employee Benefits & Payroll Taxes	0	19,007	0	0	0	0	0	0	0	0	0	19,007	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,042	0	0	0	0	0	0	0	0	0	12,042	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	2,325	0	0	0	0	0	0	0	0	0	2,325	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(87,152)	(88,911)	0	(176,063)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,057)	(73,044)	0	(168,101)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

July 1, 2005 Ending:

June 30, 2006

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	3,739	20,243	0	0	0	0	0	0	0	0	0	23,982	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,756)	272	0	0	0	0	0	0	0	0	0	(57,484)	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	(54,017)	20,515	0	(33,502)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(454,428)	0	0	0	0	0	0	0	0	0	0	(454,428)	43
44	TOTAL Special Cost Centers	(454,428)	0	0	0	0	0	0	0	0	0	0	(454,428)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(603,502)	(52,529)	0	(656,031)	45								

VII. RELATED PARTIES

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

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Christian Homes Inc	100.00%	\$ 7,035	\$ 7,035	1
2	V	6 Maintenance				8,832	8,832	2
3	V	17 Administration	312,168			65,217	(246,951)	3
4	V	19 Professional Services				14,730	14,730	4
5	V	21 Clerical				109,936	109,936	5
6	V	22 Employee Benefits				19,007	19,007	6
7	V	24 Travel & Seminar				12,042	12,042	7
8	V	26 Insurance				2,325	2,325	8
9	V	30 Depreciation				20,243	20,243	9
10	V	32 Interest				272	272	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 312,168			\$ 259,639	\$ * (52,529)	14

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

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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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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, 2005 Ending: ne 30, 2006

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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, 2005 Ending: June 30, 2006

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	1993-A GR Bonds - 90%	X		Debt Restructure	Varies	01/01/93	\$ 450,000	\$ 324,787	01/01/18	0.0650	\$ 21,364	1
2	2001-Y GR Bonds	X			Varies	10/01/01	525,000	513,013	10/01/31	0.0600	32,239	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 975,000	\$ 837,800			\$ 53,603	9
	B. Non-Facility Related*											
10	1993-A GR Bonds - 10%			Debt Restructure	Varies	01/01/93	50,000	36,087	01/01/18	0.0650	2,374	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 50,000	\$ 36,087			\$ 2,374	14
15	TOTALS (line 9+line14)						\$ 1,025,000	\$ 873,887			\$ 55,977	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 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.)		\$ N/A	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2006 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.		\$ #VALUE!	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2001	8																						
2002	9																						
2003	10																						
2004	11																						
2005	12																						
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2005 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-036-031-00</u>	<u>12-704 S36 T20 R3</u>	\$ <u>796.58</u>	\$ _____
2. <u>12-623-005-00</u>	<u>12-3054</u>	\$ <u>270.40</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,066.98</u>	\$ _____

B. Real Estate Tax Cost Allocation:

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? YES X NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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, 2005 Ending: June 30, 2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 42,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 ground:

(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)

ApartmentsCongregate BuildingDuplexesF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>42,000</u>	<u>Various</u>	<u>\$ 83,965</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>5,899</u>	<u>2</u>
3	TOTALS	42,000		\$ 89,864	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	48	1965	1965	\$ 272,125	\$ 6,411	40	\$ 6,803	\$ 392	\$ 244,649	4
5	26	1969	1969	282,500	6,637	36	7,847	1,210	257,246	5
6	26	1972	1972	318,878	7,501	33	9,663	2,162	281,236	6
7	12		2000	1,279,292	31,982	40	31,982		183,897	7
8	Home Office Allocations			49,248	6,168		6,168		15,426	8
Improvement Type**										
9	Building Improvement		1965	48,022		20				9
10	Building Improvement		1969	49,853		20				10
11	Building Improvement		1972	56,049		20				11
12	Insulation/Fire Doors		1979	11,989	266	45	266		7,204	12
13	Windows & Improvement		1980	36,891	1,054	35	1,054		28,458	13
14	Water Sentry		1980	604		5			604	14
15	Furnace		1981	2,005		15			2,005	15
16	Laundry Room		1981	4,253	125	34	125		3,188	16
17	Folding Door		1982	429		20			429	17
18	Cooling Unit		1982	7,070		15			7,070	18
19	Garage		1982	2,875		15			2,875	19
20	Roofing		1982	9,373		5			9,373	20
21	Heating Control System		1983	8,969		15			8,969	21
22	Fan		1983	243		10			243	22
23	Roof Repairs		1983	34,602		15			34,602	23
24	Office Lights		1984	487		10			487	24
25	Water Heaters		1984	2,661		15			2,661	25
26	A/C Units		1984	12,415		8			12,415	26
27	Kitchen Doors		1984	2,008		20			2,008	27
28	Compartment		1984	264		10			264	28
29	Wallpapering		1985	5,014		5			5,014	29
30	Roof Repairs		1985	50,063		5			50,063	30
31	Glazing Panels		1985	17,986	719	25	719		15,099	31
32	Windows		1985	7,800	223	35	223		4,683	32
33	Condensing Unit		1985	1,735		10			1,735	33
34	Cabinet & Sink Tops		1986	2,302		15			2,302	34
35	Building Improvement		1986	8,250	330	25	330		6,655	35
36	Gravel Roof		1986	2,986		15			2,986	36

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Access Panel	1986	\$ 111	\$	20	\$	\$ 111		37
38	A/C Unit	1986	10,500	525	20	525	10,456		38
39	Wall Cabinet	1986	191		10		191		39
40	Laundry Floor Cover	1986	1,157		5		1,157		40
41	Drapes	1986	2,282		5		2,282		41
42	Laundry Room	1986	26,110	1,306	20	1,306	25,579		42
43	Laundry Floor	1987	3,196		5		3,196		43
44	Sprinkler System	1987	120	6	20	6	116		44
45	Wall Bumper	1987	211	10	20	10	211		45
46	Fire Alarm	1987	499	25	20	25	482		46
47	Life Safety Work	1987	9,104	455	20	455	8,759		47
48	Life Safety	1987	266		10		266		48
49	Shuttering	1987	893	45	20	45	859		49
50	Wallcovering	1987	285		5		285		50
51	Carpeting	1987	1,817		5		1,817		51
52	Beauty Shop Floor	1987	618		5		618		52
53	Remodeling	1987	200		10		200		53
54	Life Safety	1987	1,284		10		1,284		54
55	Chaplains Office	1987	667		5		667		55
56	Life Safety	1987	1,875		10		1,875		56
57	Cabinets Beauty Shop	1987	558		15		558		57
58	Glass Windows	1987	2,396	120	20	120	2,250		58
59	Lights	1987	364		10		364		59
60	Metal Door	1987	440	22	20	22	409		60
61	Water Heater	1987	4,701		10		4,701		61
62	3-Ply Pitch Roof	1988	6,150		15		6,150		62
63	New A/C Work	1989	6,066	303	20	303	5,303		63
64	A/C System	1989	42,748	2,137	20	2,137	37,219		64
65	Ceiling Tiles	1989	351		5		351		65
66	Fire Dampers	1989	1,881		10		1,881		66
67	Replace Door	1989	657	33	20	33	558		67
68	Condensing Unit	1989	700		5		700		68
69	Sprinkler System	1989	4,106	205	20	205	3,451		69
70	TOTAL (lines 4 thru 69)		\$ 2,721,745	\$ 66,608		\$ 70,372	\$ 3,764	\$ 1,318,152	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, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,721,745	\$ 66,608		\$ 70,372	\$ 3,764	\$ 1,318,152	1
2	Life Safety	1989	458		10			458	2
3	Stain Glass Windows	1989	475		10			475	3
4	Remodel Dining Room	1990	2,970		10			2,970	4
5	Circulating Pump	1990	705		15			705	5
6	Replace /Install Window	1990	710	20	35	20		322	6
7	Doors	1990	508	25	20	25		398	7
8	Roofing A/C	1990	1,732	17	15	17		1,732	8
9	Water Heater	1990	2,275	20	15	20		2,275	9
10	A/C Unit	1990	10,186		10			10,186	10
11	Wallpaper	1991	2,544		5			2,544	11
12	Modular Nurse Station	1991	9,321		10			9,321	12
13	Roll Cover Base	1991	599		10			599	13
14	Wallpaper	1991	1,807		5			1,807	14
15	Wallcoverings	1991	5,774		5			5,774	15
16	A/C Compressor	1991	7,007		10			7,007	16
17	Cafeteria Window	1991	711	20	35	20		302	17
18	Base Cabinet	1991	666	44	15	44		649	18
19	Roof Work	1991	2,900	193	15	193		2,831	19
20	Water Heater	1991	1,288	86	15	86		1,254	20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		18,035	21
22	Life Safety	1992	814		20			814	22
23	Doors (5)	1992	2,550	128	20	128		1,824	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		884	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		977	26
27	Life Safety	1992	973		20			973	27
28	Furnaces	1992	13,165	658	20	658		9,048	28
29	Wall Paper	1992	3,376		5			3,376	29
30	Carpeting	1993	5,313		5			5,313	30
31	Lighting	1993	954		10			954	31
32	Air Conditioner	1993	4,475		10			4,475	32
33	Reroof	1993	8,477	385	22	385		5,037	33
34	TOTAL (lines 1 thru 33)		\$ 2,842,713	\$ 69,586		\$ 73,350	\$ 3,764	\$ 1,422,062	34

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

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,842,713	\$ 69,586		\$ 73,350	\$ 3,764	\$ 1,422,062	1
2	SW Roof	1993	900	41	22	41		526	2
3	Furnaces	1993	4,570	229	20	229		2,901	3
4	Lighting Life Safety	1994	973		10			973	4
5	Panels/Base Dayroom	1994	860		5			860	5
6	Drive Up/Curb Canopy	1994	7,108		10			7,108	6
7	Door Alarms	1994	851		5			851	7
8	Doors	1994	1,319		10			1,319	8
9	Front Entrance	1995	11,006	88	10	88		11,006	9
10	Roof	1995	6,300		5			6,300	10
11	Roof	1995	15,582	391	10	391		15,582	11
12	Front Entrance	1996	7,125	411	10	411		7,125	12
13	Roof Work	1996	3,400		5			3,400	13
14	Cnds. Unit-100	1996	2,742	253	10	253		2,742	14
15	Roof Work	1996	536		5			536	15
16	Roof Work Ewing	1996	3,062		5			3,062	16
17	Roof Repairs	1996	1,279		5			1,279	17
18	Lights & Dampers	1997	17,712	1,771	10	1,771		16,677	18
19	Courtyard Door	1997	972	97	10	97		865	19
20	Office Roof Work	1997	2,275		5			2,275	20
21	Roof Work 100 Wing	1997	13,120	1,312	10	1,312		11,589	21
22	Floor Covering	1997	2,091		5			2,091	22
23	Roof Work N&S Wing	1998	12,500	1,250	10	1,250		10,208	23
24	South Wing Roof Work	1998	14,800	1,480	10	1,480		11,889	24
25	A/C in Lobby	1998	1,226	123	10	123		994	25
26	Compressor - Laundry	1998	1,914		3			1,914	26
27	Roof Work	1999	1,920		5			1,920	27
28	Roof Work - Valley Area	1999	5,073		5			5,073	28
29	Carpeting 300 Wing	1999	11,167		5			11,167	29
30	A/C Unit 300 Wing	1999	4,284	428	10	428		3,317	30
31	Roof Work Dining Area	1999	6,590		5			6,590	31
32	Wallpaper 300 Wing	1999	12,512		5			12,512	32
33	Carpet Conference	1999	978		5			978	33
34	TOTAL (lines 1 thru 33)		\$ 3,019,460	\$ 77,460		\$ 81,224	\$ 3,764	\$ 1,587,691	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, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,019,460	\$ 77,460		\$ 81,224	\$ 3,764	\$ 1,587,691	1
2	Carpet Lobby	1999	5,021		5			5,021	2
3	Carpeting	1999	3,473		5			3,473	3
4	Office A/C Unit	1999	2,715	272	10	272		2,017	4
5	Carpeting	1999	1,743		5			1,743	5
6	Roof Work	1999	3,665		5			3,665	6
7	Remodel Beauty Shop	1999	1,339		5			1,339	7
8	Roof work	2000	5,536		5			5,536	8
9	Opto 22 energy management	2000	14,795	986	15	986		6,656	9
10	AD Smith water heater	2000	3,195	320	10	320		2,160	10
11	Water heater	2000	5,590	559	10	559		3,680	11
12	Handwash station	2000	1,140	76	15	76		494	12
13	Kitchen expansion	2000	790,605	19,765	40	19,765		125,178	13
14	Wallcover Staff DR	2000	933		5			933	14
15	Storage cabs	2000	676	45	15	45		285	15
16	Condensing unit	2000	2,530	169	15	169		1,042	16
17	Compressor laundry	2000	1,524	127	15	102	(25)	783	17
18	Heaters in Davroom	2000	1,029	69	15	69		391	18
19	Wallpaper Secretary Office	2001	2,943	342	5	342		2,943	19
20	Alzheimbers Addition	2000	90,006	2,250	40	2,250		12,938	20
21	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		14,192	21
22	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		2,708	22
23	12 SMOKE DETECTORS	2001	1,504	150	10	150		800	23
24	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		813	24
25	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		350	25
26	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		285	26
27	Compressors Etc, 300 Wing	2001	1,732		3			1,732	27
28	3 Swinging Fire Doors W/ Frames	2001	12,304	1,230	10	1,230		5,843	28
29	Main Breaker - NH	2001	4,718	472	10	472		2,203	29
30	Vinyl For Various Ares	2001	8,528	1,706	5	1,706		7,819	30
31	Carpeting - Activity Room	2001	15,290	3,058	5	3,058		14,016	31
32	Floor Coverings - 100/200 Wings	2002	28,850	5,770	5	5,770		24,042	32
33	Roof Repairs	2002	2,211	221	10	221		939	33
34	TOTAL (lines 1 thru 33)		\$ 4,067,119	\$ 118,454		\$ 122,193	\$ 3,739	\$ 1,843,710	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, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,067,119	\$ 118,454		\$ 122,193	\$ 3,739	\$ 1,843,710	1
2	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		2,083	2
3	(2) Hot water holding tanks	11/18/2002	9,434	629	15	629		2,306	3
4	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	510	10	510		1,658	4
5	Carpet/Wallpaper - Administrators Office	5/28/2003	2,555	511	5	511		1,618	5
6	Roof Repairs - 200 Hall	6/9/2003	4,600	460	10	460		1,418	6
7	10 x12 Storage shed	6/10/1999	1,578	158	10	158		1,119	7
8	Fully depreciated land improvements	6/30/1975	104,624		20			104,624	8
9	Landscaping and plants	5/23/1989	686	34	20	34		584	9
10	Survey and land clearing	5/7/1992	3,350	168	20	168		2,372	10
11	Fence, garbage area	9/30/1992	542		10			542	11
12	Landscaping entrance	5/4/1995	1,273		10			1,273	12
13	Landscaping, patio, water, lights	8/21/2000	30,266	3,026	10	3,026		17,739	13
14	Shuffleboard court	6/1/2003	785	157	5	157		484	14
15	Wallpaper 100/200 Wing - Dining Room	1/29/2004	12,387	2,477	5	2,477		6,193	15
16	Roof repair/Rehab/Nurs Stat/Day Room	10/22/2003	46,500	4,650	10	4,650		12,788	16
17	High Efficiency Ballasts/Lights	11/25/2003	15,076	1,508	10	1,508		4,021	17
18	Office Telephone Svsystem	1/15/2004	8,146	1,629	5	1,629		4,073	18
19	Business Office - Sound Proofing	12/1/2003	1,506	151	10	151		390	19
20	PT Room Renovation	1/31/2004	4,407	881	5	881		2,203	20
21	Conference Room Remodeling	1/31/2004	846	169	5	169		423	21
22	Smoke Detectors - Telephone & OT Office	3/25/2004	1,333	133	10	133		310	22
23	Network Cabling	2/16/2004	6,825	683	10	683		1,651	23
24	Smoke Detectors - Resident Rooms	4/14/2004	3,707	371	10	371		835	24
25	(20) Smoke alarms in Nursing home	4/20/2004	1,617	162	10	162		365	25
26	Computer Upgrade on Energy Mgmt System	4/14/2004	6,000	600	10	600		1,350	26
27	Roof Repairs - 400 Wing	6/14/2004	4,500	450	10	450		938	27
28	Wanderguard System	6/17/2004	842	168	5	168		350	28
29	3 Ton A/C for Laundry	6/30/2004	2,386	239	10	239		498	29
30	A/C Unit - 100 Hall	6/30/2004	1,231	123	10	123		256	30
31	(4) Call Cord Stations	10/20/2004	770	154	5	154		270	31
32	Remodel Front Entrance/Business Office	10/1/2004	11,056	2,211	5	2,211		3,869	32
33	Install Dampers/Misc Energy Mgmt Work	3/11/2005	1,434	478	5	478		637	33
34	TOTAL (lines 1 thru 33)		\$ 4,367,581	\$ 141,854		\$ 145,593	\$ 3,739	\$ 2,022,950	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 4,367,581	\$ 141,854		\$ 145,593	\$ 3,739	\$ 2,022,950		1
2	Roof Repairs	3/29/2005 33,088	3,309	10	3,309		4,412		2
3	Add'l Smoke Detectors (Life Safety)	3/25/2005 1,585	159	10	159		212		3
4	Generator Upgrade (Life Safety)	4/1/2005 2,621	262	10	262		328		4
5	Fireproof Window Casing in Business Office	4/6/2005 1,823	365	5	365		456		5
6	Therapy Room Painting	7/7/2005 500	100	5	100		100		6
7	Therapy Room Improvements	7/4/2005 1,098	110	10	110		110		7
8	Mural Painting In Therapy Gym	9/15/2005 3,000	500	5	500		500		8
9	Therapy Area New Flooring	7/11/2005 3,460	692	5	692		692		9
10	Window For 300 Wing Day Room	1/1/2006 750	38	10	38		38		10
11	Roof Repairs Over 300 Hall	11/30/2005 11,800	787	10	787		787		11
12	(14) GE Zoneline AC Units For 300	4/13/2006 15,400	770	5	770		770		12
13	Parking Lot South Side of Bldg	6/26/2006 15,350	85	15	85		85		13
14	Sidewalk Between Nursing Home	4/13/2006 3,795	95	10	95		95		14
15	Rock & Delivery For Parking Lot On N	11/14/2005 878	117	5	117		117		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,462,729	\$ 149,243		\$ 152,982	\$ 3,739	\$ 2,031,652		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, 2005

Ending:

June 30, 2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 642,120	\$ 72,140	\$ 72,140	\$	Various	\$ 327,477	71
72	Current Year Purchases	97,656	6,945	6,945		Various	6,945	72
73	Fully Depreciated Assets	326,055				Various	326,055	73
74	Home Office Allocation	100,269	12,557	12,557			75,728	74
75	TOTALS	\$ 1,166,100	\$ 91,642	\$ 91,642	\$		\$ 736,205	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Bus	1992	\$ 38,828	\$	\$	\$	8	\$ 38,828	76
77	Patient Transportation	2000 Chevy Van w/lift	9/9/2003	8,432	2,811	2,811		3	7,965	77
78	Non Patient Transportation	1999 Ford Ranger	2006	4,800	400	400			400	78
79	Home Office Allocation			12,123	1,518	1,518			1,519	79
80	TOTALS			\$ 64,183	\$ 4,729	\$ 4,729	\$		\$ 48,712	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)	\$	5,782,876	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	245,614	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	249,353	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	3,739	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,816,569	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	Apartment	\$ 455,402	\$ 17,225	\$ 360,636	86
87	Congregate	2,112,855	58,607	1,180,315	87
88	Land	230,405			88
89	Duplex	1,763,338	48,081	930,652	89
90					90
91	TOTALS	\$ 4,562,000	\$ 123,913	\$ 2,471,603	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 2,690	92
93			93
94			94
95		\$ 2,690	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

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

		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

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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: _____ *

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: \$ _____ 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist	This	hrs											2
3	Licensed Recreational Therapist	workpaper	hrs											3
4	Licensed Physical Therapist	is not	hrs											4
5	Physician Care	applicable.	visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2006 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 108,311	\$	1
2	Cash-Patient Deposits	1,909		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 57,031)	617,949		3
4	Supply Inventory (priced at FIFO)	16,556		4
5	Short-Term Investments	977,954		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,019		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int Rec</u>	14,808		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,745,506	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,369		13
14	Buildings, at Historical Cost	8,286,636		14
15	Leasehold Improvements, at Historical Cost	224,052		15
16	Equipment, at Historical Cost	1,352,278		16
17	Accumulated Depreciation (book methods)	(5,194,982)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,170,426		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,152,779	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,898,285	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 125,895	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,909		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,179		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	533		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Liabilities</u>	38,184		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 403,700	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	873,887		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Apt. Income</u>	485,264		43
44	<u>Apt & Cong Life Right & Sec</u>	856,576		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,215,727	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,619,427	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,278,858	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,898,285	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,875,357	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,875,357	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	616,453	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)	\$ 616,453	17
B. Transfers (Itemize):			
18	Transfer - Affiliate	(1,212,952)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,212,952)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,278,858	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: July 1, 2005

Page 19
Ending: June 30, 2006

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,669,553	1
2	Discounts and Allowances for all Levels	(833,107)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,836,446	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	316,644	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 316,644	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	27,947	13
14	Non-Patient Meals	918	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,223	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,148	19
20	Radiology and X-Ray	16,727	20
21	Other Medical Services	2,599	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,562	23
D. Non-Operating Revenue			
24	Contributions	163,159	24
25	Interest and Other Investment Income***	134,016	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 297,175	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Sale of Equity	(34,887)	28
28a	Residential/Congregate	731,564	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 696,677	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,211,504	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	926,151	31
32	Health Care	2,399,738	32
33	General Administration	1,423,926	33
B. Capital Expense			
34	Ownership	281,479	34
C. Ancillary Expense			
35	Special Cost Centers	502,443	35
36	Provider Participation Fee	61,314	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,595,051	40
41	Income before Income Taxes (line 30 minus line 40)**	616,453	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 616,453	43

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

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

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

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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,769	1,957	\$ 68,146	\$ 34.82	1
2	Assistant Director of Nursing	1,339	1,371	31,840	23.22	2
3	Registered Nurses	4,040	4,737	169,186	35.72	3
4	Licensed Practical Nurses	30,426	35,139	579,323	16.49	4
5	CNAs & Orderlies	80,200	90,754	825,828	9.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,984	3,993	53,268	13.34	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	14,254	15,607	139,726	8.95	11
12	Dietician					12
13	Food Service Supervisor	1,714	1,959	38,796	19.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,610	13,115	137,488	10.48	15
16	Dishwashers					16
17	Maintenance Workers	6,046	6,666	82,974	12.45	17
18	Housekeepers	14,389	15,862	128,790	8.12	18
19	Laundry	4,209	4,662	40,694	8.73	19
20	Administrator	1,652	1,937	157,290	81.20	20
21	Assistant Administrator	1,956	2,176	45,479	20.90	21
22	Other Administrative					22
23	Office Manager	1,829	2,055	27,564	13.41	23
24	Clerical	2,609	2,751	28,829	10.48	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					31
32	Other Health Care MDS Coordinator	3,349	3,859	86,864	22.51	32
33	Other(specify) Ward Clerk, Com	5,728	6,195	114,738	18.52	33
34	TOTAL (lines 1 - 33)	191,103	214,795	\$ 2,756,823 *	\$ 12.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	193	\$ 8,506	3.1.3	35
36	Medical Director	6	2,300	3.9.3	36
37	Medical Records Consultant	16	2,847	3.10.3	37
38	Nurse Consultant	228	14,070	3.10.3	38
39	Pharmacist Consultant	8	3,114	3.10.3	39
40	Physical Therapy Consultant	1,258	72,462	3.10a.3	40
41	Occupational Therapy Consultant	917	54,995	3.10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	653	47,398	3.10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	88	5,074	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,367	\$ 210,766		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Charlotte Bennett	Administrator	0	\$ 157,290	Workers' Compensation Insurance	\$ 114,982	IDPH License Fee	\$	
Bart Taylor	Asst. Admin.	0	45,479	Unemployment Compensation Insurance	1,384	Advertising: Employee Recruitment	23,205	
				FICA Taxes	204,322	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	211,840	Patient Background Checks		
				Employee Meals		Licenses & Dues	8,620	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	3,861	
				W C Medical Expense	129	Remote Fee & Support	3,737	
				Employee Expense	18,519	Other	1,404	
				Employee Physicals	4,272	Advertising & Promotions	16,230	
				Home Office Allocation	19,007	Less: Public Relations Expense (
						Non-allowable advertising	(16,230)	
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 202,769	TOTAL (agree to Schedule V, line 22, col.8)	\$ 574,455	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,827	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Expense			\$ 312,168				Out-of-State Travel	\$
							In-State Travel	5,333
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 312,168				Seminar Expense	4,116
							Home Office Allocation	12,042
C. Professional Services								
Vendor/Payee	Type		Amount					
Foley & Lardener, LLP	Legal		\$ 113				Other Costs	
The Finn Group	Legal		400				375	
Davis & Campbell	Legal		2,884				Entertainment Expense (
							(agree to Sch. V,	
							line 24, col. 8)	
							\$ 21,866	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,397	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2005 Ending: June 30, 200**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. \$6,846 Life Services Network & \$200 INHAA
- (3) Did the nursing home make political contributions or payments to a political 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,127 Line 3.10.2
- (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 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. \$ 61,314
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 918
- (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. \$ 0
- 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: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.