

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Highway Flanagan 61740
 Number City Zip Code

County: Livingston

Telephone Number: 815-796-2267 **Fax #** 815-796-4434

HFS ID Number: 37-0841562008

Date of Initial License for Current Owners: 1970

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Susan McGhee **Telephone Number:** 217-732-5175

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 2006 to June 2007 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) <u>Tim Phillippe</u>	
	(Title) <u>CEO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Allan B. Larson</u> <u>Principal</u>	
	(Firm Name & Address) <u>LarsonAllen@ LLP</u> <u>12801 Flushing Meadows Dr., Suite 100, St. Louis, MO 63131</u>	
	(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</u>	

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 Beulah Land Christian Home# 0006767 Report Period Beginning: July 2006 Ending: June 2007

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	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>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>32</u>	Sheltered Care (SC)	<u>32</u>	<u>11,680</u>	5
6		ICF/DD 16 or Less			6
7	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,158</u>	<u>2,746</u>	<u>2,616</u>	<u>12,520</u>	8
9	SNF/PED					9
10	ICF	<u>306</u>			<u>306</u>	10
11	ICF/DD					11
12	SC	<u>335</u>	<u>3,590</u>		<u>3,925</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,799</u>	<u>6,336</u>	<u>2,616</u>	<u>16,751</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.19%

D. How many bed-hold days during this year were paid by the Department?

NONE (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? YES

G. 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 1970

J. 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 43 and days of care provided 2,212Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 2006 Ending: June 2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	142,763	13,430	4,499	160,692		160,692		160,692		1
2	Food Purchase		109,756		109,756		109,756	(3,508)	106,248		2
3	Housekeeping	93,639	18,676	401	112,716		112,716		112,716		3
4	Laundry										4
5	Heat and Other Utilities			88,313	88,313		88,313	(825)	87,488		5
6	Maintenance	34,141	6,971	24,700	65,812		65,812	1,904	67,716		6
7	Other (specify):* Trash Removal			1,620	1,620		1,620		1,620		7
8	TOTAL General Services	270,543	148,833	119,533	538,909		538,909	(2,429)	536,480		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	743,736	121,604	102,866	968,206		968,206	(44,607)	923,599		10
10a	Therapy			149,522	149,522		149,522		149,522		10a
11	Activities	4,243			4,243		4,243	(619)	3,624		11
12	Social Services	80,359	1,194	4,478	86,031		86,031	(1)	86,030		12
13	CNA Training										13
14	Program Transportation			2,372	2,372		2,372		2,372		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	828,338	122,798	264,038	1,215,174		1,215,174	(45,227)	1,169,947		16
	C. General Administration										
17	Administrative	52,077	1,687	133,083	186,847		186,847	(103,708)	83,139		17
18	Directors Fees										18
19	Professional Services			3,500	3,500		3,500	15,079	18,579		19
20	Dues, Fees, Subscriptions & Promotions			49,724	49,724		49,724	(16,046)	33,678		20
21	Clerical & General Office Expenses	80,896	9,993	47,757	138,646		138,646	50,748	189,394		21
22	Employee Benefits & Payroll Taxes			245,255	245,255		245,255	10,520	255,775		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,548	13,548		13,548	6,814	20,362		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,910	47,910		47,910	433	48,343		26
27	Other (specify):*										27
28	TOTAL General Administration	132,973	11,680	540,777	685,430		685,430	(36,160)	649,270		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,231,854	283,311	924,348	2,439,513		2,439,513	(83,816)	2,355,697		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 Beulah Land Christian Home

#0006767

Report Period Beginning:

July 2006

Ending:

June 2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			101,792	101,792		101,792	8,699	110,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,159	25,159		25,159	(18,845)	6,314			32
33	Real Estate Taxes			401	401		401		401			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Purchased Services			93	93		93		93			36
37	TOTAL Ownership			127,445	127,445		127,445	(10,146)	117,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,257	5,257		5,257		5,257			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			102	102		102		102			41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			28,902	28,902		28,902		28,902			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,231,854	283,311	1,080,695	2,595,860		2,595,860	(93,962)	2,501,898			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 Beulah Land Christian Home

0006767

Report Period Beginning: July 2006

Ending: June 2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,421)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,873)	5		5
6	Rented Facility Space	(300)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(43,027)	32		10
11	Discounts, Allowances, Rebates & Refunds	(41)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,968	21		24
25	Fund Raising, Advertising and Promotional	(16,046)	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	14,235			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,505)		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (49,505)		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

BHF USE ONLY						
48		49		50		51
						52

Beulah Land Christian Home

ID# 0006767

Report Period Beginning: July 2006

Ending: June 2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ (1,087)	2	1
2	Activity	(619)	11	2
3	Exempt Interest Income - Endowment	24,083	32	3
4	Late Fees	15	6	4
5	Late Fees	(1)	12	5
6	Late Fees	(83)	21	6
7	Late Fees	(150)	10	7
8	Fines & Penalties	(7,923)	21	8
9	Pharmacy - Chargeable	(44,457)	10	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(30,222)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beulah Land Christian Home# 0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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	(3,508)	0	0	0	0	0	0	0	0	0	0	(3,508)	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	(5,173)	4,348	0	0	0	0	0	0	0	0	0	(825)	5
6	Maintenance	15	1,889	0	0	0	0	0	0	0	0	0	1,904	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,666)	6,237	0	(2,429)	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	(44,607)	0	0	0	0	0	0	0	0	0	0	(44,607)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(619)	0	0	0	0	0	0	0	0	0	0	(619)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(45,227)	0	0	0	0	0	0	0	0	0	0	(45,227)	16
	C. General Administration													
17	Administrative	0	(103,708)	0	0	0	0	0	0	0	0	0	(103,708)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,079	0	0	0	0	0	0	0	0	0	15,079	19
20	Fees, Subscriptions & Promotions	(16,046)	0	0	0	0	0	0	0	0	0	0	(16,046)	20
21	Clerical & General Office Expenses	(5,079)	55,827	0	0	0	0	0	0	0	0	0	50,748	21
22	Employee Benefits & Payroll Taxes	0	10,520	0	0	0	0	0	0	0	0	0	10,520	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,814	0	0	0	0	0	0	0	0	0	6,814	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	433	0	0	0	0	0	0	0	0	0	433	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,125)	(15,035)	0	(36,160)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,018)	(8,798)	0	(83,816)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006 Ending:

June 2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	8,699	0	0	0	0	0	0	0	0	0	8,699	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,944)	99	0	0	0	0	0	0	0	0	0	(18,845)	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	(18,944)	8,798	0	(10,146)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(93,962)	0	0	0	0	0	0	0	0	0	0	(93,962)	45

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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 attached 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%	\$ 4,348	\$ 4,348
2	V	6 Maintenance				1,889	1,889
3	V	17 Administrative	135,396			31,688	(103,708)
4	V	19 Professional Fees				15,079	15,079
5	V	21 Clerical				55,827	55,827
6	V	22 Employee Benefits				10,520	10,520
7	V	32 Interest				99	99
8	V	24 Travel and Seminars				6,814	6,814
9	V	26 Insurance				433	433
10	V	30 Depreciation				8,699	8,699
11	V						
12	V						
13	V						
14	Total		\$ 135,396			\$ 135,396	\$ *

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

Facility Name & ID Number

Beulah Land Christian Home

#

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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									
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13								TOTAL	\$	

* 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 Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending: June 2007

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	This workpaper is not applicable.				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	1996-A GR Bonds	X		Operations		7/1/96	\$ 225,000	\$	7/1/21	0.0675	\$ 11,099	1
2	2001-X GR Bond	X		Operations	\$1,298.00	10/1/01	200,000	192,533	10/1/31	0.0650	12,586	2
3	2001-Y GR Bonds	X		Operations	\$1,229.00	10/1/01	176,700	176,700	10/1/31	0.0675	994	3
4	Bond Financing Fee										480	4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related				\$2,527.00		\$ 601,700	\$ 369,233			\$ 25,159	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 601,700	\$ 369,233			\$ 25,159	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 2006 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 2007 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																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2002</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2006</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2002	_____	8		2003	_____	9		2004	_____	10		2005	_____	11		2006	_____	12
Real Estate Tax Bill for Calendar Year:	2002	_____	8																				
	2003	_____	9																				
	2004	_____	10																				
	2005	_____	11																				
	2006	_____	12																				
<table border="1"> <tr> <td colspan="4">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY				13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beulah Land Christian Home COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0006767

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>13-27-203-001</u>	<u>See Attached</u>	\$ <u>298.00</u>	\$ _____
2. <u>13-27-226-004</u>	<u>See Attached</u>	\$ <u>100.00</u>	\$ _____
3. <u>13-27-201-015</u>	<u>See Attached</u>	\$ <u>3.00</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>401.00</u>	\$ _____

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? 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Beulah Land Christian Home

0006767 Report Period Beginning:

July 2006 Ending:

June 2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. 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 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).

NONE

F. 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>16,000</u>	<u>Various</u>	\$ <u>1,303</u>	1
2	<u>Home Office Allocation</u>			<u>2,450</u>	2
3	TOTALS	16,000		\$ 3,753	3

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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	43		1982	1982	\$ 1,279,926	\$ 31,998	40	\$ 31,998		\$ 801,283	4
5	32		1974	1974	417,998	8,360	50	8,360		306,417	5
6											6
7											7
8	Home Office Allocation				21,132	2,619		2,619		33,113	8
	Improvement Type**										
9	Land Improvement			1977	7,756	155	50	155		4,729	9
10	Insulated Windows			1979	16,273	370	44	370		10,237	10
11	Ceiling Replaced			1981	1,118	26	43	26		702	11
12	Heating & A/C			1982	25,614		20			25,614	12
13	Bldg Improvement			1982	28,428	711	40	711		17,805	13
14	Bldg Improvement			1982	7,375	184	40	184		4,570	14
15	Bldg Improvement			1982	36,352	909	40	909		22,343	15
16	Insulation			1983	4,400	147	30	147		3,601	16
17	Improvements			1983	2,925	98	30	98		2,368	17
18	Hot Water System			1985	1,577		20			1,577	18
19	Edge Protectors, Etc			1985	507		15			507	19
20	Light Fixtures			1985	406		15			406	20
21	Garage Work			1985	23,170		15			23,170	21
22	Ceiling Tiles			1985	225		15			225	22
23	Bldg Improvement			1986	36,762	919	40	919		19,759	23
24	Light Fixtures - 1/2			1987	610		10			610	24
25	Window 1/2			1987	840	35	20	35		840	25
26	Hot Water System 1/2			1988	979	49	20	49		947	26
27	Chg Water Piping 1/2			1988	390	20	20	20		387	27
28	Water Heater Consult			1988	961		15			961	28
29	Door Alarm System			1988	1,900	95	20	95		1,789	29
30	Vinyl Siding			1988	3,410	170	20	170		3,205	30
31	Door Monitor Panel			1989	1,980		10			1,980	31
32	Compressors (2)			1989	924		10			924	32
33	Compressors			9/12/1989	2,306		10			2,306	33
34	Compressor (1)			1989	693		10			693	34
35	Emerg Power Kitchen Light			1990	329		5			329	35
36											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 Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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	Lavatories/Faucets	1990	\$ 1,679	\$	5	\$	\$	\$ 1,679	37
38	Carpeting	1990	300		5			300	38
39	Compressor	1991	1,828		10			1,828	39
40	Insulating Glass	1991	2,256	68	33	68		1,065	40
41	Door Monitor	1992	1,440		10			1,440	41
42	Room Windows (3)	1992	2,696	135	20	135		1,991	42
43	A/C Units (5)	1992	5,859		8			5,859	43
44	Sinks/Faucets	1993	537		5			537	44
45	Door Monitor	1993	1,700		10			1,700	45
46	Mix Valve/Faucet	1993	2,953		10			2,953	46
47	Auto Sprinkler	1993	580		10			580	47
48	Door Access System	1993	602		10			602	48
49	Wallcoverings	1993	5,315		5			5,315	49
50	Carpet/Wallpaper	1993	9,540		5			9,540	50
51	Drapes	1994	4,878		10			4,878	51
52	Roofing Project Shelter	1994	62,189	4,146	15	4,146		53,898	52
53	Install Carrier Furnace	1994	1,877		10			1,877	53
54	Nurse Call System	1995	1,040	69	15	69		851	54
55	Upstairs Lib/Comp Room	1995	1,743		10			1,743	55
56	Garage Doors	1995	676		5			676	56
57	Wanderguard	1995	4,094		10			4,094	57
58	A/C Heating Units	1995	2,326		8			2,326	58
59	Heating/AC Units	1995	4,652		8			4,652	59
60	Carrier Central A/C	1995	2,748		10			2,748	60
61	Heating/AC Units	1995	2,326		8			2,326	61
62	Water Heater	1996	6,263		10			6,263	62
63	200 Gallon Storage Tank	1996	4,115		10			4,115	63
64	Remodel Nursing Wing	1996	3,249		5			3,249	64
65	Heating/AC Units	1996	5,235		8			5,235	65
66	Mixer/Amp	1997	975	77	10	77		975	66
67	Water Heater	1997	13,453	1,236	10	1,236		13,453	67
68	Eyewash Station	1997	555		5			555	68
69	Exit Lights	1997	1,102	110	10	110		1,082	69
70	TOTAL (lines 4 thru 69)		\$ 2,088,047	\$ 52,706		\$ 52,706	\$	\$ 1,443,782	70

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

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,088,047	\$ 52,706		\$ 52,706	\$	\$ 1,443,782	1
2	York C/A Unit	1997	7,839	784	10	784		7,644	2
3	Floor Covering	1997	1,856		5			1,856	3
4	Wall Covering Sit & Bath	1998	2,574		5			2,574	4
5	Floor Covering - Sit & Bath	1998	1,145		5			1,145	5
6	Carpeting	1998	8,739		5			8,739	6
7	Wallpaper	1998	7,497		5			7,497	7
8	Room Signs	1998	2,270		5			2,270	8
9	Paint/Wallpaper/Carpet	1999	17,404	1,740	10	1,740		14,790	9
10	Remodel Nurses Station	1999	2,700	180	15	180		1,470	10
11	Floor Tile/Cove Base	2000	1,144		5			1,144	11
12	Carpet/Cove Base 2 Rooms	2000	576		5			576	12
13	A/C Grill Covers (13)	2000	546		5			546	13
14	Shelter Care Hallway CA	2000	3,686		5			3,686	14
15	Floor Covering	2000	1,040		5			1,040	15
16	Fire Alarm System	2000	32,965	3,297	10	3,297		24,452	16
17	Floor Tile/Cove Base	2000	1,755		5			1,755	17
18	Remodel - Chapel/Act/Bs/Dr	2000	10,705	1,070	10	1,070		7,674	18
19	AC HEATING UNIT INSTALLED	2000	505	34	15	34		227	19
20	FLOOR COVERINGS	2000	1,143		5			1,143	20
21	ENTRY SYSTEM KEYPAD/ALZ. WING	2001	775		5			775	21
22	DOOR ALARM SYSTEM	2001	1,155	115	10	115		705	22
23	Mixing Valve Installation	2001	1,649	165	10	165		990	23
24	Canopy over patio area	2001	6,612	661	10	661		3,801	24
25	Steel Door/East Side of Kitchen	2001	1,393	139	10	139		776	25
26	Floor Coverings - Rooms 404 & 417	9/27/2002	886	177	5	177		856	26
27	(2) Thru Wall Unit A/C	10/18/2002	1,348	169	8	169		802	27
28	Carrier thru-wall HTG/AC unit	3/27/2003	625	42	15	42		181	28
29	80' Red Oak Handrail & Installation	4/21/2003	2,160	144	15	144		612	29
30	Apartment Conversion	2/1/2003	31,913	2,127	15	2,127		9,397	30
31	Railing - Asst Living Loft Area	4/25/2003	3,456	346	10	346		1,471	31
32	Wiring run for Steamer & Steam Table	4/4/2003	1,644	82	20	82		349	32
33	Tile Bathrooms - Rooms 414/417/423-Carpet 423	5/30/2003	817	163	5	163		679	33
34	TOTAL (lines 1 thru 33)		\$ 2,248,569	\$ 64,141		\$ 64,141	\$	\$ 1,555,404	34

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

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006 Ending:

June 2007

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		\$ 2,248,569	\$ 64,141		\$ 64,141	\$	\$ 1,555,404	1
2	Compressor for Laundry A/C	7/21/2003	767		3			767	2
3	Roof Replacement	9/3/2003	31,762	2,117	15	2,117		7,939	3
4	Add Sprinkler in Mechanical Room	9/26/2003	535	107	5	107		410	4
5	High Efficiency Ballasts/Lights	11/11/2003	12,351	1,235	10	1,235		4,528	5
6	Explosion Proof Light in O2 Room	12/9/2003	1,250	250	5	250		896	6
7	Upgrade Energy Management System	3/2/2004	6,000	429	14	429		1,430	7
8	Addition to Fire Ext System	4/8/2004	1,338	134	10	134		436	8
9	Install Fire Wall in A/L Dining Room	5/20/2004	2,855	571	5	571		1,808	9
10	Fully depreciated land improvements	6/30/1974	83,212		20			83,212	10
11	Water & sewer line	11/30/1980	12,325	411	30	411		10,700	11
12	Parking lot lighting	10/31/1983	3,642		20			3,642	12
13	Sidewalk	11/30/1987	10,600	424	25	424		8,339	13
14	New sidewalk & move fire hydrant	12/12/1989	1,725	61	20	61		1,893	14
15	Outside lights	1/5/1994	2,099		10			2,099	15
16	Landscaping	6/30/1995	8,515		10			8,515	16
17	Concrete pad	6/5/1998	3,571	357	10	357		3,243	17
18	Landscaping	8/13/1998	578		5			578	18
19	Patio	11/17/2000	4,090	409	10	409		2,727	19
20	Landscaping	6/30/2001	1,975		5			1,975	20
21	Landscaping and fence	10/25/2001	16,799	1,680	10	1,680		9,828	21
22	Repair & Seal Parking Lot	7/25/2003	3,097		3			3,097	22
23	Carpet/Vinyl (Res Rm on SC side)	7/2/2004	705	141	5	141		423	23
24	5T Carrier Central AC Unit	8/20/2004	2,001	200	10	200		583	24
25	Carpet/Vinyl Cover Base Rm 415 A/L	12/31/2004	890	178	5	178		460	25
26	Gas log fireplace w/screens	1/4/2005	909	182	5	182		455	26
27	(2) Base Cabinets w/Formica top	3/30/2005	574	57	10	57		133	27
28	(6) Heat/AC Units & Installation	5/13/2005	4,105	513	8	513		1,112	28
29	Sidewalk	9/5/2005	2,945	295	10	295		540	29
30	Door Replacement Room 305	3/17/2006	1,576	158	10	158		210	30
31	Carpeting Rooms #420, 422, 424, 440	2/9/2006	3,908	782	5	782		1,108	31
32	Install Sprinkler Heads In MDS	8/2/2005	519	52	10	52		100	32
33	(3) PR Joerns Assist Devices W/Moun	5/5/2006	534	53	10	53		62	33
34	TOTAL (lines 1 thru 33)		\$ 2,476,321	\$ 74,937		\$ 74,937	\$	\$ 1,718,652	34

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

Facility Name & ID Number Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006 Ending:

June 2007

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		\$ 2,476,321	\$ 74,937		\$ 74,937	\$	\$ 1,718,652	1
2	New Flooring NH Hallways	6/14/2006	6,283	1,257	5	1,257		1,362	2
3	New Carpeting & Installation	11/14/2006	888	118	5	118		118	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,483,492	\$ 76,312		\$ 76,312	\$	\$ 1,720,132	34

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

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 2006 Ending: June 2007

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	\$ 221,260	\$ 27,237	\$ 27,237	\$	Various	\$ 135,836	71
72	Current Year Purchases	25,501	862	862		Various	862	72
73	Fully Depreciated Assets	258,422				Various	258,422	73
74	Home Office Allocation	44,594	5,528	5,528			9,825	74
75	TOTALS	\$ 549,777	\$ 33,627	\$ 33,627	\$		\$ 404,945	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	2000 Ford Van	2000	\$ 47,500	\$	\$	\$	4	\$ 47,500	76
77										77
78										78
79	Home Office Allocation			4,456	552	552			1,540	79
80	TOTALS			\$ 51,956	\$ 552	\$ 552	\$		\$ 49,040	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)	\$ 3,088,978	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,491	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)	\$ 2,174,117	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	Land	\$ 13,576	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 13,576	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 6,086	92
93			93
94			94
95		\$ 6,086	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?

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>Training was provided by a local area vocational school</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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

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

Facility Name & ID Number Beulah Land Christian Home# 0006767Report Period Beginning: July 2006

Ending:

June 2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 2007

(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	\$ 203,366	\$	1
2	Cash-Patient Deposits	4,884		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (22,393))	324,082		3
4	Supply Inventory (priced at)	13,896		4
5	Short-Term Investments	103,795		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	3,444		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 653,467	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,879		13
14	Buildings, at Historical Cost	2,307,187		14
15	Leasehold Improvements, at Historical Cost	155,172		15
16	Equipment, at Historical Cost	555,192		16
17	Accumulated Depreciation (book methods)	(2,129,639)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	583,634		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,486,425	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,139,892	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 69,021	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,884		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,128		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	189		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>	27,165		36
37	<u>FIN 47 Liability</u>	51,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 261,387	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	367,762		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 367,762	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 629,149	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,510,743	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,139,892	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,610,947	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Insurance Accrual	17,840	3
4	Prior Period Adjustment - FIN 47	(51,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,577,787	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(77,043)	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)	\$ (77,043)	17
	B. Transfers (Itemize):		
18	Transfer to Affiliate	10,000	18
19	Rounding	(1)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 9,999	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,510,743	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Beulah Land Christian Home# 0006767Report Period Beginning: July 2006Ending: June 2007**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	\$ 2,681,211	1
2	Discounts and Allowances for all Levels	(582,195)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,099,016	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,637	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 247,637	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	900	13
14	Non-Patient Meals	2,421	14
15	Telephone, Television and Radio	4,873	15
16	Rental of Facility Space	300	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,753	19
20	Radiology and X-Ray	30	20
21	Other Medical Services	1,747	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,024	23
D. Non-Operating Revenue			
24	Contributions	70,037	24
25	Interest and Other Investment Income***	43,027	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 113,064	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain on Sale of Investments</u>	43,076	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 43,076	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,518,817	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	538,909	31
32	Health Care	1,215,174	32
33	General Administration	685,430	33
B. Capital Expense			
34	Ownership	127,445	34
C. Ancillary Expense			
35	Special Cost Centers	5,359	35
36	Provider Participation Fee	23,543	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,595,860	40
41	Income before Income Taxes (line 30 minus line 40)**	(77,043)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (77,043)	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 Beulah Land Christian Home

0006767

Report Period Beginning:

July 2006

Ending:

June 2007

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	1,785	2,205	\$ 58,695	\$ 26.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,225	3,529	84,934	24.07	3
4	Licensed Practical Nurses	7,712	8,607	175,993	20.45	4
5	CNAs & Orderlies	30,175	32,521	359,200	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,033	1,123	11,408	10.16	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	5,612	6,248	80,366	12.86	11
12	Dietician					12
13	Food Service Supervisor	1,830	2,083	30,313	14.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,388	13,216	112,449	8.51	15
16	Dishwashers					16
17	Maintenance Workers	1,808	2,072	34,131	16.47	17
18	Housekeepers	10,077	11,377	93,639	8.23	18
19	Laundry					19
20	Administrator	1,831	2,070	52,077	25.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,584	1,907	30,885	16.20	23
24	Clerical					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 Ward Clerk	808	895	9,398	10.50	32
33	Other(specify) <u>Marketing, Vol. Co</u>	3,883	4,047	98,366	24.31	33
34	TOTAL (lines 1 - 33)	82,751	91,900	\$ 1,231,854 *	\$ 13.40	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	96	\$ 4,430	3.1.3	35
36	Medical Director	96	4,800	3.9.3	36
37	Medical Records Consultant	26	1,752	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	838	3.10.3	39
40	Physical Therapy Consultant	1,285	81,547	3.10a.3	40
41	Occupational Therapy Consultant	987	61,235	3.10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	73	6,739	3.10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	64	4,372	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,687	\$ 165,713		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,465	\$ 60,507	3.10.3	50
51	Licensed Practical Nurses	710	26,013	3.10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,175	\$ 86,520		53

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. Life Services Network - \$2,908.74
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,159 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 23,543
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. \$ 2,421
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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: LarsonAllen@ 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? NO If no, please explain. It will be sent when audit is complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.