

		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: 0004630

Facility Name: Christian Nursing Home

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

County: Logan

Telephone Number: 217-732-2189 **Fax #** 217-735-1904

HFS ID Number: 37-0841562004

Date of Initial License for Current Owners: 09/01/1965

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 1, 2006 to June 30, 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>Chief Executive Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u>	
	(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Drive, Suite 100, St. Louis, MO 631</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 Christian Nursing Home# 0004630 Report Period Beginning: July, 1, 2006 Ending: June 30, 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>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 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,288</u>	<u>16,712</u>	<u>4,760</u>	<u>36,760</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>15,288</u>	<u>16,712</u>	<u>4,760</u>	<u>36,760</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.92%

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? 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 09/01/1995

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 112 and days of care provided 4,577Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July, 1, 2006 Ending: June 30, 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	185,874	34,170	7,563	227,607		227,607		227,607		1
2	Food Purchase		213,256		213,256		213,256	(550)	212,706		2
3	Housekeeping	168,793	35,069		203,862		203,862		203,862		3
4	Laundry										4
5	Heat and Other Utilities			133,082	133,082		133,082	8,392	141,474		5
6	Maintenance	85,573	8,205	59,481	153,259		153,259	4,034	157,293		6
7	Other (specify):* Trash Removal			3,296	3,296		3,296		3,296		7
8	TOTAL General Services	440,240	290,700	203,422	934,362		934,362	11,876	946,238		8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	1,841,193	250,233	356,212	2,447,638		2,447,638	(110,759)	2,336,879		10
10a	Therapy			247,844	247,844		247,844		247,844		10a
11	Activities	4,248			4,248		4,248	(723)	3,525		11
12	Social Services	151,836	2,619	5,957	160,412		160,412		160,412		12
13	CNA Training										13
14	Program Transportation			4,684	4,684		4,684	(3,120)	1,564		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,997,277	252,852	617,997	2,868,126		2,868,126	(114,602)	2,753,524		16
	C. General Administration										
17	Administrative	112,920	894	322,546	436,360		436,360	(253,540)	182,820		17
18	Directors Fees										18
19	Professional Services			8,101	8,101		8,101	32,836	40,937		19
20	Dues, Fees, Subscriptions & Promotions			45,782	45,782		45,782	(17,552)	28,230		20
21	Clerical & General Office Expenses	193,728	11,605	64,437	269,770		269,770	25,947	295,717		21
22	Employee Benefits & Payroll Taxes			572,284	572,284		572,284	22,909	595,193		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,611	8,611		8,611	14,837	23,448		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,579	54,579		54,579	943	55,522		26
27	Other (specify):*										27
28	TOTAL General Administration	306,648	12,499	1,076,340	1,395,487		1,395,487	(173,620)	1,221,867		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,744,165	556,051	1,897,759	5,197,975		5,197,975	(276,346)	4,921,629		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, 2006 Ending:

June 30, 2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			222,648	222,648	222,648	22,559	245,207				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,808	50,808	50,808	(50,592)	216				32
33	Real Estate Taxes			1,130	1,130	1,130	(1,130)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Financing Fee			1,128	1,128	1,128		1,128				36
37	TOTAL Ownership			275,714	275,714	275,714	(29,163)	246,551				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			35,252	35,252	35,252		35,252				39
40	Barber and Beauty Shops			26,374	26,374	26,374		26,374				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320	61,320		61,320				42
43	Other (specify):* Apt./Congregate			487,774	487,774	487,774	(487,774)					43
44	TOTAL Special Cost Centers			610,720	610,720	610,720	(487,774)	122,946				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,744,165	556,051	2,784,193	6,084,409	6,084,409	(793,283)	5,291,126				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, 2006

Ending: June 30, 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	(1,799)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,076)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,615	30		9
10	Interest and Other Investment Income	(148,568)	32		10
11	Discounts, Allowances, Rebates & Refunds	(267)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,257)	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	(5,988)	21		24
25	Fund Raising, Advertising and Promotional	(17,552)	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	(491,002)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (664,894)		\$	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))	\$ (664,894)		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

Christian Nursing Home

ID# 0004630

Report Period Beginning: July, 1, 2006

Ending: June 30, 2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ 1,249	2	1
2	Activity	(723)	11	2
3	Exempt Interest - Endowment	83,175	32	3
4	Transportation	(3,120)	14	4
5	Late Fees	(78)	6	5
6	Late Fees	(327)	21	6
7	Marketing Salaries	(82,389)	21	7
8	Marketing Other Expenses	(6,355)	21	8
9	Apt/Congregate	(487,774)	43	9
10	Fines & Penalties	(297)	21	10
11	RE Tax on Vacant Lots	(1,130)	33	11
12	Interest	16,842	32	12
13	Pharmacy Chargeable	(110,759)	10	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	(591,686)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July, 1, 2006

Ending:

June 30, 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	(550)	0	0	0	0	0	0	0	0	0	0	(550)	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	(1,076)	9,468	0	0	0	0	0	0	0	0	0	8,392	5
6	Maintenance	(78)	4,112	0	0	0	0	0	0	0	0	0	4,034	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,704)	13,580	0	11,876	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	(110,759)	0	0	0	0	0	0	0	0	0	0	(110,759)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(723)	0	0	0	0	0	0	0	0	0	0	(723)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,120)	0	0	0	0	0	0	0	0	0	0	(3,120)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(114,602)	0	0	0	0	0	0	0	0	0	0	(114,602)	16
	C. General Administration													
17	Administrative	0	(253,540)	0	0	0	0	0	0	0	0	0	(253,540)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	32,836	0	0	0	0	0	0	0	0	0	32,836	19
20	Fees, Subscriptions & Promotions	(17,552)	0	0	0	0	0	0	0	0	0	0	(17,552)	20
21	Clerical & General Office Expenses	(95,623)	121,570	0	0	0	0	0	0	0	0	0	25,947	21
22	Employee Benefits & Payroll Taxes	0	22,909	0	0	0	0	0	0	0	0	0	22,909	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,837	0	0	0	0	0	0	0	0	0	14,837	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	943	0	0	0	0	0	0	0	0	0	943	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(113,175)	(60,445)	0	(173,620)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(229,481)	(46,865)	0	(276,346)	29								

STATE OF ILLINOIS

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July, 1, 2006 Ending:

Summary B
June 30, 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	3,615	18,944	0	0	0	0	0	0	0	0	0	22,559	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50,808)	216	0	0	0	0	0	0	0	0	0	(50,592)	32
33	Real Estate Taxes	(1,130)	0	0	0	0	0	0	0	0	0	0	(1,130)	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	(48,323)	19,160	0	(29,163)	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):*	(487,774)	0	0	0	0	0	0	0	0	0	0	(487,774)	43
44	TOTAL Special Cost Centers	(487,774)	0	0	0	0	0	0	0	0	0	0	(487,774)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(765,578)	(27,705)	0	(793,283)	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 attached listing of board of directors.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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%	\$ 9,468	\$ 9,468
2	V	6 Maintenance				4,112	4,112
3	V	17 Administration	322,546			69,006	(253,540)
4	V	19 Professional Services				32,836	32,836
5	V	21 Clerical				121,570	121,570
6	V	22 Employee Benefits				22,909	22,909
7	V	24 Travel & Seminar				14,837	14,837
8	V	26 Insurance				943	943
9	V	30 Depreciation				18,944	18,944
10	V	32 Interest				216	216
11	V						
12	V						
13	V						
14	Total		\$ 322,546			\$ 294,841	\$ * (27,705)

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

Facility Name & ID Number

Christian Nursing Home

#

0004630

Report Period Beginning:

July, 1, 2006

Ending:

June 30, 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 Christian Nursing Home

0004630 Report Period Beginning: July, 1, 2006 Ending: ne 30, 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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>This workpaper is not applicable</u>				\$	\$		\$	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	1993-A GR Bonds - 90%	X		Debt Restructure	Varies	01/01/93	\$ 450,000	\$ 308,250	01/01/18	0.0650	\$ 20,310	1								
2	2001-Y GR Bonds	X			Varies	10/01/01	525,000	505,400	10/01/31	0.0600	30,497	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 975,000	\$ 813,650			\$ 50,807	9								
B. Non-Facility Related*																				
10	1993-A GR Bonds - 10%			Debt Restructure	Varies	01/01/93	50,000	34,250	01/01/18	0.0650	2,257	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 50,000	\$ 34,250			\$ 2,257	14								
15	TOTALS (line 9+line14)						\$ 1,025,000	\$ 847,900			\$ 53,064	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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 Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>12-036-031-00</u>	<u>12-704 S36 T20 R3</u>	\$ <u>827.00</u>	\$ _____
2. <u>12-623-005-00</u>	<u>12-3054</u>	\$ <u>281.00</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,108.00</u>	\$ <u>_____</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? X YES _____ 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 Christian Nursing Home

0004630 Report Period Beginning:

July, 1, 2006 Ending:

June 30, 2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (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).

Apartments

Congregate Building

Duplexes

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>42,000</u>	<u>Various</u>	<u>\$ 83,965</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>5,336</u>	<u>2</u>
3	TOTALS	42,000		\$ 89,301	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July, 1, 2006 Ending: June 30, 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	48		1965	1965	\$ 272,125	\$ 6,411	40	\$ 6,803	\$ 392	\$ 251,060	4	
5	26		1969	1969	282,500	6,637	36	7,847	1,210	263,883	5	
6	26		1972	1972	318,878	7,501	33	9,663	2,162	288,737	6	
7	12			2000	1,279,292	31,834	40	31,834		215,880	7	
8	Home Office Allocations				46,018	5,704		5,704		72,108	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		7,471	12	
13	Windows & Improvements			1980	36,891	1,054	35	1,054		29,512	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		3,313	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		15,819	31	
32	Windows			1985	7,800	223	35	223		4,906	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		6,985	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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July, 1, 2006 Ending: June 30, 2007

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Access Panel	1986	\$ 111	\$	20	\$	\$	\$ 111	37
38	A/C Unit	1986	10,500	44	20	44		10,500	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	531	20	531		26,110	42
43	Laundry Floor	1987	3,196		5			3,196	43
44	Sprinkler System	1987	120	4	20	4		120	44
45	Wall Bumper	1987	211		20			211	45
46	Fire Alarm	1987	499	17	20	17		499	46
47	Life Safety Work	1987	9,104	345	20	345		9,104	47
48	Life Safety	1987	266		10			266	48
49	Shuttering	1987	893	34	20	34		893	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		2,370	58
59	Lights	1987	364		10			364	59
60	Metal Door	1987	440	22	20	22		431	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		5,607	63
64	A/C System	1989	42,748	2,137	20	2,137		39,357	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		591	67
68	Condensing Unit	1989	700		5			700	68
69	Sprinkler System	1989	4,106	205	20	205		3,657	69
70	TOTAL (lines 4 thru 69)		\$ 2,718,515	\$ 64,748		\$ 68,363	\$ 3,764	\$ 1,433,883	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, 2006 Ending: June 30, 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 12A, Carried Forward		\$ 2,718,515	\$ 64,748		\$ 68,363	\$ 3,615	\$ 1,433,883	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	0	343	6
7	Doors	1990	508	25	20	25		424	7
8	Roofing A/C	1990	1,732		15			1,732	8
9	Water Heater	1990	2,275		15			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		323	17
18	Base Cabinet	1991	666	17	15	17		666	18
19	Roof Work	1991	2,900	69	15	69		2,900	19
20	Water Heater	1991	1,288	34	15	34		1,288	20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		19,287	21
22	Life Safety	1992	814		20			814	22
23	Doors (5)	1992	2,550	128	20	128		1,951	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		946	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		1,046	26
27	Life Safety	1992	973		20			973	27
28	Furnaces	1992	13,165	658	20	658		9,707	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		5,423	33
34	TOTAL (lines 1 thru 33)		\$ 2,839,483	\$ 67,486		\$ 71,101	\$ 3,615	\$ 1,540,536	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, 2006 Ending: June 30, 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		\$ 2,839,483	\$ 67,486		\$ 71,101	\$ 3,615	\$ 1,540,536	1
2	SW Roof	1993	900	41	22	41		567	2
3	Furnaces	1993	4,570	229	20	229		3,129	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		10			11,006	9
10	Roof	1995	6,300		5			6,300	10
11	Roof	1995	15,582		10			15,582	11
12	Front Entrance	1996	7,125		10			7,125	12
13	Roof Work	1996	3,400		5			3,400	13
14	Cnds. Unit-100	1996	2,742		10			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	1,035	10	1,035		17,712	18
19	Courtyard Door	1997	972	97	10	97		962	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		12,901	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		11,458	23
24	South Wing Roof Work	1998	14,800	1,480	10	1,480		13,369	24
25	A/C in Lobby	1998	1,226	123	10	123		1,116	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		3,746	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)		\$ 3,016,230	\$ 73,481		\$ 77,096	\$ 3,615	\$ 1,712,159	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, 2006 Ending: June 30, 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		\$ 3,016,230	\$ 73,481		\$ 77,096	\$ 3,615	\$ 1,712,159	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		2,288	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		7,643	9
10	AD Smith water heater	2000	3,195	320	10	320		2,479	10
11	Water heater	2000	5,590	559	10	559		4,239	11
12	Handwash station	2000	1,140	76	15	76		570	12
13	Kitchen expansion	2000	790,605	19,765	40	19,765		144,943	13
14	Wallcover Staff DR	2000	933		5			933	14
15	Storage cabs	2000	676	45	15	45		330	15
16	Condensing unit	2000	2,530	169	15	169		1,210	16
17	Compressor laundry	2000	1,524	127	12	127		910	17
18	Heaters in Dayroom	2000	1,029	69	15	69		459	18
19	Wallpaper Secretary Office	2001	2,943		5			2,943	19
20	Alzheimbers Addition	2000	90,006	2,250	40	2,250		15,188	20
21	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		16,812	21
22	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		3,208	22
23	12 SMOKE DETECTORS	2001	1,504	150	10	150		951	23
24	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		973	24
25	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		420	25
26	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		341	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		7,074	28
29	Main Breaker - NH	2001	4,718	472	10	472		2,675	29
30	Vinyl For Various Ares	2001	8,528	709	5	709		8,528	30
31	Carpeting - Activity Room	2001	15,290	1,274	5	1,274		15,290	31
32	Floor Coverings - 100/200 Wings	2002	28,850	4,808	5	4,808		28,850	32
33	Roof Repairs	2002	2,211	221	10	221		1,160	33
34	TOTAL (lines 1 thru 33)		\$ 4,063,889	\$ 110,390		\$ 114,005	\$ 3,615	\$ 2,005,085	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, 2006 Ending: June 30, 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 12D, Carried Forward		\$ 4,063,889	\$ 110,390		\$ 114,005	\$ 3,615	\$ 2,005,085	1
2	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		2,593	2
3	(2) Hot water holding tanks	11/18/2002	9,434	629	15	629		2,935	3
4	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	510	10	510		2,168	4
5	Carpets/Wallpaper - Administrators Office	5/28/2003	2,555	511	5	511		2,129	5
6	Roof Repairs - 200 Hall	6/9/2003	4,600	460	10	460		1,878	6
7	10 x12 Storage shed	6/10/1999	1,578	158	10	158		1,277	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		619	9
10	Survey and land clearing	5/7/1992	3,350	168	20	168		2,539	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		20,766	13
14	Shuffleboard court	6/1/2003	785	157	5	157		641	14
15	Wallpaper 100/200 Wing - Dining Room	1/29/2004	12,387	2,477	5	2,477		8,671	15
16	Roof repair/Rehab/Nurs Stat/Day Room	10/22/2003	46,500	4,650	10	4,650		17,438	16
17	High Efficiency Ballasts/Lights	11/25/2003	15,076	1,508	10	1,508		5,528	17
18	Office Telephone System	1/15/2004	8,146	1,629	5	1,629		5,702	18
19	Business Office - Sound Proofing	12/1/2003	1,506	151	10	151		540	19
20	PT Room Renovation	1/31/2004	4,407	881	5	881		3,085	20
21	Conference Room Remodeling	1/31/2004	846	169	5	169		592	21
22	Smoke Detectors - Telephone & OT Office	3/25/2004	1,333	133	10	133		444	22
23	Network Cabling	2/16/2004	6,825	683	10	683		2,333	23
24	Smoke Detectors - Resident Rooms	4/14/2004	3,707	371	10	371		1,205	24
25	(20) Smoke alarms in Nursing home	4/20/2004	1,617	162	10	162		526	25
26	Computer Upgrade on Energy Mgmt System	4/14/2004	6,000	600	10	600		1,950	26
27	Roof Repairs - 400 Wing	6/14/2004	4,500	450	10	450		1,388	27
28	Wanderguard System	6/17/2004	842	168	5	168		519	28
29	3 Ton A/C for Laundry	6/30/2004	2,386	239	10	239		736	29
30	A/C Unit - 100 Hall	6/30/2004	1,231	123	10	123		379	30
31	(4) Call Cord Stations	10/20/2004	770	154	5	154		424	31
32	Remodel Front Entrance/Business Office	10/1/2004	11,056	2,211	5	2,211		6,080	32
33	Install Dampers/Misc Energy Mgmt Work	3/11/2005	1,434	478	3	478		1,115	33
34	TOTAL (lines 1 thru 33)		\$ 4,364,351	\$ 133,790		\$ 137,405	\$ 3,615	\$ 2,207,724	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, 2006 Ending: June 30, 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 12E, Carried Forward		\$ 4,364,351	\$ 133,790		\$ 137,405	\$ 3,615	\$ 2,207,724	1
2	Roof Repairs	3/29/2005	33,088	3,309	10	3,309		7,721	2
3	Add'l Smoke Detectors (Life Safety)	3/25/2005	1,585	159	10	159		370	3
4	Generator Upgrade (Life Safety)	4/1/2005	2,621	262	10	262		590	4
5	Fireproof Window Casing in Business Office	4/6/2005	1,823	365	5	365		820	5
6	Therapy Room Painting	7/7/2005	500	100	5	100		200	6
7	Therapy Room Improvements	7/4/2005	1,098	110	10	110		220	7
8	Mural Painting In Therapy Gym	9/15/2005	3,000	600	5	600		1,100	8
9	Therapy Area New Flooring	7/11/2005	3,460	692	5	692		1,384	9
10	Window For 300 Wing Day Room	1/1/2006	750	75	10	75		112	10
11	Roof Repairs Over 300 Hall	11/30/2005	11,800	1,180	10	1,180		1,967	11
12	(14) GE Zoneline AC Units For 300	4/13/2006	15,400	3,080	5	3,080		3,850	12
13	Parking Lot South Side of Bldg	6/26/2006	15,350	1,023	15	1,023		1,107	13
14	Sidewalk Between Nursing Home	4/13/2006	3,795	380	10	380		474	14
15	Rock & Delivery For Parking Lot On N	11/14/2005	878	176	5	176		292	15
16	5 ton, 3 phase compressor	9/29/2006	1,981	550	3	550		550	16
17	Front door and 300 hall SE door	12/29/2006	3,794	147	15	147		147	17
18	Install Laundry RTU & 30x20	8/8/2006	6,113	560	10	560		560	18
19	Install new floor in dining room	1/9/2007	3,155	315	5	315		315	19
20	Additions to fire alarm system	12/14/2006	1,235	144	5	144		144	20
21	Install tile flooring Nurses Station	2/1/2007	5,752	120	20	120		120	21
22	Install tile flooring Nurses Station	3/1/2007	1,355	23	20	23		23	22
23	Carpet and Vinyl floorcovering	3/1/2007	1,925	128	5	128		128	23
24	New Vinyl Flooring- Alzheimers	6/27/2007	787	13	5	13		13	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)		\$ 4,485,596	\$ 147,301		\$ 150,916	\$ 3,615	\$ 2,229,931	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, 2006 Ending: June 30, 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	\$ 708,256	\$ 76,569	\$ 76,569	\$	various	\$ 736,153	71
72	Current Year Purchases	29,931	2,302	2,302		various	2,302	72
73	Fully Depreciated Assets	355,976				various	355,976	73
74	Home Office Allocation	97,108	12,037	12,037			21,396	74
75	TOTALS	\$ 1,191,271	\$ 90,908	\$ 90,908	\$		\$ 1,115,827	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 & Chevy Van w/ Lift	2/27/1992	\$ 47,260	\$ 467	\$ 467	\$	3	\$ 47,260	76
77	Non Patient Transportation	1999 Ford Ranger	4/11/2006	4,800	1,600	1,600		3	2,000	77
78	Non Patient Transportation	5'x14' Tandem Axle Trailer	4/11/2006	900	113	113		8	113	78
79	Home Office Allocation			9,704	1,203	1,203			3,354	79
80	TOTALS			\$ 62,664	\$ 3,383	\$ 3,383	\$		\$ 52,727	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)	\$ 5,828,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 241,592	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,207	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,615	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,398,485	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	\$ 457,767	\$ 16,497	\$ 377,133	86
87	Congregate	2,136,038	59,089	1,239,287	87
88	Duplex	1,763,340	49,314	979,968	88
89	Land	230,405			89
90					90
91	TOTALS	\$ 4,587,550	\$ 124,900	\$ 2,596,388	91

G. Construction-in-Progress

	Description	Cost	
92	Architecture designs	\$ 9,180	92
93	Home Office Allocation	13,254	93
94			94
95		\$ 22,434	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: July, 1, 2006

Ending: June 30, 2007

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>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	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 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 Christian Nursing Home # 0004630 Report Period Beginning: July, 1, 2006 Ending: June 30, 2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 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	\$ 2,427,139	\$	1
2	Cash-Patient Deposits	9,625		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>47,024</u>)	643,698		3
4	Supply Inventory (priced at)	18,758		4
5	Short-Term Investments	481,513		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,822		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Rec.</u>	12,490		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,598,045	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,370		13
14	Buildings, at Historical Cost	8,348,351		14
15	Leasehold Improvements, at Historical Cost	224,053		15
16	Equipment, at Historical Cost	1,390,749		16
17	Accumulated Depreciation (book methods)	(5,542,038)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,901,071		21
22	Other Long-Term Assets (spe <u>CIP</u>)	9,180		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,645,736	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,243,781	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 194,213	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,625		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,486		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	554		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>	20,460		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 485,338	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	25,988		40
41	Bonds Payable	819,899		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Apartment Income</u>	819,359		43
44	<u>Apt & Cong Life Right & Sec</u>	770,153		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,435,399	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,920,737	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,323,044	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,243,781	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,278,858	1
2	Restatements (describe):		2
3	<u>Prior Period Adjustment - Insurance Accrual</u>	38,876	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,317,734	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,055,311	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)	\$ 1,055,311	17
B. Transfers (Itemize):			
18	<u>Transfer - Affiliate</u>	(50,000)	18
19	<u>Rounding</u>	(1)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (50,001)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,323,044	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July, 1, 2006Ending: June 30, 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	\$ 5,797,205	1
2	Discounts and Allowances for all Levels	(721,381)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,075,824	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	891,846	6
7	Oxygen	283	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 892,129	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	25,658	13
14	Non-Patient Meals	1,799	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,076	16
17	Sale of Drugs	1,659	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,957	19
20	Radiology and X-Ray	13,047	20
21	Other Medical Services	8,554	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 78,750	23
D. Non-Operating Revenue			
24	Contributions	128,716	24
25	Interest and Other Investment Income***	148,568	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 277,284	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized Gain(Loss) on Investments	109,306	28
28a	Residential/Congregate	706,427	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 815,733	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,139,720	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	934,362	31
32	Health Care	2,868,126	32
33	General Administration	1,395,487	33
B. Capital Expense			
34	Ownership	275,714	34
C. Ancillary Expense			
35	Special Cost Centers	549,400	35
36	Provider Participation Fee	61,320	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,084,409	40
41	Income before Income Taxes (line 30 minus line 40)**	1,055,311	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,055,311	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, 2006

Ending:

June 30, 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	1,688	2,045	\$ 91,572	\$ 44.78	1
2	Assistant Director of Nursing	2,432	2,538	56,632	22.31	2
3	Registered Nurses	4,802	5,696	126,699	22.24	3
4	Licensed Practical Nurses	28,065	32,525	546,192	16.79	4
5	CNAs & Orderlies	73,408	84,453	845,530	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,927	5,728	63,992	11.17	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	14,929	16,862	153,417	9.10	11
12	Dietician					12
13	Food Service Supervisor	1,874	2,029	37,460	18.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,138	18,776	148,414	7.90	15
16	Dishwashers					16
17	Maintenance Workers	6,229	7,008	85,573	12.21	17
18	Housekeepers	18,964	21,439	168,793	7.87	18
19	Laundry					19
20	Administrator	1,770	2,100	112,920	53.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,859	2,110	29,324	13.90	23
24	Clerical	3,420	3,822	38,565	10.09	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	2,089	2,286	28,637	12.53	32
33	Other(specify) <u>Marketing, CNL, V</u>	8,113	8,890	210,445	23.67	33
34	TOTAL (lines 1 - 33)	191,707	218,307	\$ 2,744,165 *	\$ 12.57	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	157	\$ 7,440	35
36	Medical Director	5	3,300	36
37	Medical Records Consultant	16	2,487	37
38	Nurse Consultant	26	2,678	38
39	Pharmacist Consultant	8	3,145	39
40	Physical Therapy Consultant	4,181	268,618	40
41	Occupational Therapy Consultant	3,429	224,237	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	795	81,579	43
44	Activity Consultant			44
45	Social Service Consultant	83	4,806	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	8,700	\$ 598,290	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

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. \$6,755 Life Services Network & \$100 INHAA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,697 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,799
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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? _____ 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 \$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.