

Facility Name & ID Number Christian Nursing Home# 0004630 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,992</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>40,992</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>15,170</u>	<u>16,052</u>	<u>5,414</u>	<u>36,636</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>15,170</u>	<u>16,052</u>	<u>5,414</u>	<u>36,636</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.37%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Meals, Lawn & Maint Care, Housekeeping/Laundry services for I/L residentsF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/1995

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 4,979Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

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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	196,915	38,852	10,199	245,966		245,966		245,966		1
2	Food Purchase		243,629		243,629		243,629	(1,692)	241,937		2
3	Housekeeping	176,918	22,687	4,490	204,095		204,095		204,095		3
4	Laundry		6,325		6,325		6,325		6,325		4
5	Heat and Other Utilities			155,184	155,184		155,184	5,920	161,104		5
6	Maintenance	90,583	6,494	53,705	150,782		150,782	2,849	153,631		6
7	Other (specify):* Trash Removal			3,703	3,703		3,703		3,703		7
8	TOTAL General Services	464,416	317,987	227,281	1,009,684		1,009,684	7,077	1,016,761		8
	B. Health Care and Programs										
9	Medical Director			3,150	3,150		3,150		3,150		9
10	Nursing and Medical Records	1,827,036	286,213	28,731	2,141,980	(146,067)	1,995,913		1,995,913		10
10a	Therapy			705,492	705,492		705,492		705,492		10a
11	Activities							591	591		11
12	Social Services	201,705	2,766	5,260	209,731		209,731		209,731		12
13	CNA Training										13
14	Program Transportation			5,099	5,099		5,099	(3,633)	1,466		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,028,741	288,979	747,732	3,065,452	(146,067)	2,919,385	(3,042)	2,916,343		16
	C. General Administration										
17	Administrative	153,374	298	363,300	516,972		516,972	(304,599)	212,373		17
18	Directors Fees										18
19	Professional Services			13,059	13,059		13,059	36,973	50,032		19
20	Dues, Fees, Subscriptions & Promotions			61,940	61,940		61,940	(16,731)	45,209		20
21	Clerical & General Office Expenses	188,204	9,199	58,276	255,679		255,679	50,772	306,451		21
22	Employee Benefits & Payroll Taxes			454,868	454,868		454,868	13,886	468,754		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,001	9,001		9,001	14,268	23,269		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,716	90,716		90,716	1,004	91,720		26
27	Other (specify):*										27
28	TOTAL General Administration	341,578	9,497	1,051,160	1,402,235		1,402,235	(204,427)	1,197,808		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,834,735	616,463	2,026,173	5,477,371	(146,067)	5,331,304	(200,392)	5,130,912		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.

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			208,984	208,984		208,984	14,616	223,600		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			74,585	74,585		74,585	(32,456)	42,129		32
33	Real Estate Taxes			1,131	1,131		1,131	(1,131)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			22,857	22,857		22,857		22,857		35
36	Other (specify):* Financing Fees			1,152	1,152		1,152		1,152		36
37	TOTAL Ownership			308,709	308,709		308,709	(18,971)	289,738		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			67,802	67,802	146,067	213,869		213,869		39
40	Barber and Beauty Shops			30,830	30,830		30,830		30,830		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			61,488	61,488		61,488		61,488		42
43	Other (specify):* Apt/Congregate			490,703	490,703		490,703	(490,703)			43
44	TOTAL Special Cost Centers			650,823	650,823	146,067	796,890	(490,703)	306,187		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,834,735	616,463	2,985,705	6,436,903		6,436,903	(710,066)	5,726,837		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

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,971)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(3,298)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,551	30		9
10	Interest and Other Investment Income	(32,456)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34)	21		24
25	Fund Raising, Advertising and Promotional	(16,731)	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	(590,853)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (643,792)		\$	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)	(66,274)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,274)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (710,066)		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	X		146,067	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 146,067		47

BHF USE ONLY					
48		49		50	51
					52

Christian Nursing Home

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ 279	2	1
2	Activity	591	11	2
3	Transportation	(3,633)	14	3
4	Late Fees	(17)	21	4
5	Marketing Salaries	(95,056)	21	5
6	Marketing Other Expenses	(1,183)	21	6
7	Apt / Congregate	(490,703)	43	7
8	RE Tax on Vacant Lots	(1,131)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(590,853)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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	(1,692)	0	0	0	0	0	0	0	0	0	0	(1,692)	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	(3,298)	9,218	0	0	0	0	0	0	0	0	0	5,920	5
6	Maintenance	0	2,849	0	0	0	0	0	0	0	0	0	2,849	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,990)	12,067	0	7,077	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	591	0	0	0	0	0	0	0	0	0	0	591	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	(3,633)	0	0	0	0	0	0	0	0	0	0	(3,633)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,042)	0	0	0	0	0	0	0	0	0	0	(3,042)	16
	C. General Administration													
17	Administrative	0	(304,599)	0	0	0	0	0	0	0	0	0	(304,599)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	36,973	0	0	0	0	0	0	0	0	0	36,973	19
20	Fees, Subscriptions & Promotions	(16,731)	0	0	0	0	0	0	0	0	0	0	(16,731)	20
21	Clerical & General Office Expenses	(96,290)	147,062	0	0	0	0	0	0	0	0	0	50,772	21
22	Employee Benefits & Payroll Taxes	0	13,886	0	0	0	0	0	0	0	0	0	13,886	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,268	0	0	0	0	0	0	0	0	0	14,268	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,004	0	0	0	0	0	0	0	0	0	1,004	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(113,021)	(91,406)	0	(204,427)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,053)	(79,339)	0	(200,392)	29								

STATE OF ILLINOIS

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Summary B
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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	1,551	13,065	0	0	0	0	0	0	0	0	0	14,616	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,456)	0	0	0	0	0	0	0	0	0	0	(32,456)	32
33	Real Estate Taxes	(1,131)	0	0	0	0	0	0	0	0	0	0	(1,131)	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	(32,036)	13,065	0	(18,971)	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):*	(490,703)	0	0	0	0	0	0	0	0	0	0	(490,703)	43
44	TOTAL Special Cost Centers	(490,703)	0	0	0	0	0	0	0	0	0	0	(490,703)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(643,792)	(66,274)	0	(710,066)	45								

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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%	\$ 9,218	\$ 9,218	1
2	V	6 Maintenance				2,849	2,849	2
3	V	17 Administration	363,300			58,701	(304,599)	3
4	V	19 Professional Services				36,973	36,973	4
5	V	21 Clerical				147,062	147,062	5
6	V	22 Employee Benefits				13,886	13,886	6
7	V	24 Travel & Seminar				14,268	14,268	7
8	V	26 Insurance				1,004	1,004	8
9	V	30 Depreciation				13,065	13,065	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 363,300			\$ 297,026	\$ * (66,274)	14

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

Facility Name & ID Number

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Report Period Beginning:

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VII. RELATED PARTIES (continued)

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

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Series 2007 Project Fund		X	Renovation Projects		6/30/07	\$ 382,171	\$ 382,171	6/30/2031	0.0560	\$ 22,667	1								
2	Bond Fund	X		Debt Restructure	\$1,976.00	Varies	1,025,000	826,085	6/30/2032	Various	51,918	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$1,976.00		\$ 1,407,171	\$ 1,208,256			\$ 74,585	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,407,171	\$ 1,208,256			\$ 74,585	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>839.00</u>	\$ _____
2. <u>12-623-005-00</u>	<u>12-3054</u>	\$ <u>285.00</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,124.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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, 2007 Ending:

June 30, 2008

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>	1
2	<u>Home Office Allocation</u>			<u>4,704</u>	2
3	TOTALS	42,000		\$ 88,669	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	\$ 5,039	54	\$ 5,928	\$ 889	\$ 254,904	4	
5	26		1969	1969	282,500	5,650	50	6,154	504	265,269	5	
6	26		1972	1972	318,878	6,785	47	6,943	158	299,549	6	
7	12			2000	1,279,292	31,834	40	31,834		247,714	7	
8	Home Office Allocation				43,798	3,067		3,067		72,813	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		7,737	12	
13	Windows & Improvements			1980	36,891	1,054	35	1,054		30,566	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		3,438	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		16,538	31	
32	Windows			1985	7,800	223	35	223		5,129	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		7,315	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, 2007 Ending: June 30, 2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Access Panel	1986	\$ 111	\$	20	\$	\$	\$ 111	37
38	A/C Unit	1986	10,500		20			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		20			26,110	42
43	Laundry Floor	1987	3,196		5			3,196	43
44	Sprinkler System	1987	120		20			120	44
45	Wall Bumper	1987	211		20			211	45
46	Fire Alarm	1987	499		20			499	46
47	Life Safety Work	1987	9,104		20			9,104	47
48	Life Safety	1987	266		10			266	48
49	Shuttering	1987	893		20			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	26	20	26		2,396	58
59	Lights	1987	364		10			364	59
60	Metal Door	1987	440	9	20	9		440	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		5,910	63
64	A/C System	1989	42,748	2,137	20	2,137		41,494	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		624	67
68	Condensing Unit	1989	700		5			700	68
69	Sprinkler System	1989	4,106	205	20	205		3,862	69
70	TOTAL (lines 4 thru 69)		\$ 2,716,295	\$ 57,805		\$ 59,356	\$ 1,551	\$ 1,487,894	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, 2007 Ending: June 30, 2008

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		\$ 2,716,295	\$ 57,805		\$ 59,356	\$ 1,551	\$ 1,487,894	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	363	6
7	Doors	1990	508	25	20	25		449	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		353	17
18	Base Cabinet	1991	666		15			666	18
19	Roof Work	1991	2,900		15			2,900	19
20	Water Heater	1991	1,288		15			1,288	20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		20,538	21
22	Life Safety	1992	814		20			814	22
23	Doors (5)	1992	2,550	128	20	128		2,079	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		1,008	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		1,115	26
27	Life Safety	1992	973		20			973	27
28	Furnaces	1992	13,165	658	20	658		10,365	28
29	Wall Paper	1992	3,376		5			3,376	29
30									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		5,817	33
34	TOTAL (lines 1 thru 33)		\$ 2,831,950	\$ 60,423		\$ 61,974	\$ 1,551	\$ 1,591,871	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, 2007 Ending: June 30, 2008

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		\$ 2,831,950	\$ 60,423		\$ 61,974	\$ 1,551	\$ 1,591,871	1
2	SW Roof	1993	900	41	22	41		608	2
3	Furnaces	1993	4,570	229	20	229		3,358	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		10			17,712	18
19	Courtyard Door	1997	972	10	10	10		972	19
20	Office Roof Work	1997	2,275		5			2,275	20
21	Roof Work 100 Wing	1997	13,120	219	10	219		13,120	21
22	Floor Covering	1997	2,091		5			2,091	22
23	Roof Work N&S Wing	1998	12,500	1,042	10	1,042		12,500	23
24	South Wing Roof Work	1998	14,800	1,431	10	1,431		14,800	24
25	A/C in Lobby	1998	1,226	110	10	110		1,226	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		4,174	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)		\$ 3,008,697	\$ 63,933		\$ 65,484	\$ 1,551	\$ 1,767,004	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, 2007 Ending: June 30, 2008

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		\$ 3,008,697	\$ 63,933		\$ 65,484	\$ 1,551	\$ 1,767,004	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		2,560	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		8,629	9
10	AD Smith water heater	2000	3,195	320	10	320		2,799	10
11	Water heater	2000	5,590	559	10	559		4,798	11
12	Handwash station	2000	1,140	76	15	76		346	12
13	Kitchen expansion	2000	790,605	19,765	40	19,765		164,708	13
14	Wallcover Staff DR	2000	933		5			933	14
15	Storage cabs	2000	676	45	15	45		375	15
16	Condensing unit	2000	2,530	169	15	169		1,379	16
17	Compressor laundry	2000	1,524	127	12	127		1,037	17
18	Heaters in Dayroom	2000	1,029	69	15	69		528	18
19	Wallpaper Secretary Office	2001	2,943		5			2,943	19
20	Alzheimbers Addition	2000	90,006	2,250	40	2,250		17,438	20
21	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		19,432	21
22	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		3,708	22
23	12 SMOKE DETECTORS	2001	1,504	150	10	150		1,101	23
24	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		1,133	24
25	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		490	25
26	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		398	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		8,304	28
29	Main Breaker - NH	2001	4,718	472	10	472		3,147	29
30	Vinyl For Various Ares	2001	8,528		5			8,528	30
31	Carpeting - Activity Room	2001	15,290		5			15,290	31
32	Floor Coverings - 100/200 Wings	2002	28,850		5			28,850	32
33	Roof Repairs	2002	2,211	221	10	221		1,381	33
34	TOTAL (lines 1 thru 33)		\$ 4,056,356	\$ 94,051		\$ 95,602	\$ 1,551	\$ 2,089,748	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, 2007 Ending: June 30, 2008

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		\$ 4,056,356	\$ 94,051		\$ 95,602	\$ 1,551	\$ 2,089,748	1
2	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		2,603	2
3	(2) Hot water holding tanks	11/18/2002	9,434	629	15	629		3,564	3
4	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	510	10	510		2,678	4
5	Carpet/Wallpaper - Administrators Office	5/28/2003	2,555	426	5	426		2,555	5
6	Roof Repairs - 200 Hall	6/9/2003	4,600	460	10	460		2,338	6
7	10 x12 Storage shed	6/10/1999	1,578	158	10	158		1,435	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		653	9
10	Survey and land clearing	5/7/1992	3,350	168	20	168		2,707	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		23,792	13
14	Shuffleboard court	6/1/2003	785	144	5	144		785	14
15	Wallpaper 100/200 Wing - Dining Room	1/29/2004	12,387	2,477	5	2,477		11,148	15
16	Roof repair/Rehab/Nurs Stat/Day Room	10/22/2003	46,500	4,650	10	4,650		22,088	16
17	High Efficiency Ballasts/Lights	11/25/2003	15,076	1,508	10	1,508		7,036	17
18	Office Telephone System	1/15/2004	8,146	1,629	5	1,629		7,331	18
19	Business Office - Sound Proofing	12/1/2003	1,506	151	10	151		691	19
20	PT Room Renovation	1/31/2004	4,407	881	5	881		3,966	20
21	Conference Room Remodeling	1/31/2004	846	169	5	169		761	21
22	Smoke Detectors - Telephone & OT Office	3/25/2004	1,333	133	10	133		577	22
23	Network Cabling	2/16/2004	6,825	683	10	683		3,016	23
24	Smoke Detectors - Resident Rooms	4/14/2004	3,707	371	10	371		1,576	24
25	(20) Smoke alarms in Nursing home	4/20/2004	1,617	162	10	162		688	25
26	Computer Upgrade on Energy Mgmt System	4/14/2004	6,000	600	10	600		2,550	26
27	Roof Repairs - 400 Wing	6/14/2004	4,500	450	10	450		1,838	27
28	Wanderguard System	6/17/2004	842	168	5	168		687	28
29	3 Ton A/C for Laundry	6/30/2004	2,386	239	10	239		975	29
30	A/C Unit - 100 Hall	6/30/2004	1,231	123	10	123		502	30
31	(4) Call Cord Stations	10/20/2004	770	154	5	154		578	31
32	Remodel Front Entrance/Business Office	10/1/2004	11,056	2,211	5	2,211		8,291	32
33	Install Dampers/Misc Energy Mgmt Work	3/11/2005	1,434	319	3	319		1,434	33
34	TOTAL (lines 1 thru 33)		\$ 4,356,818	\$ 117,194		\$ 118,745	\$ 1,551	\$ 2,315,030	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, 2007 Ending: June 30, 2008

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		\$ 4,356,818	\$ 117,194		\$ 118,745	\$ 1,551	\$ 2,315,030	1
2	Roof Repairs	3/29/2005	33,088	3,309	10	3,309		11,030	2
3	Add'l Smoke Detectors (Life Safety)	3/25/2005	1,585	159	10	159		529	3
4	Generator Upgrade (Life Safety)	4/1/2005	2,621	262	10	262		852	4
5	Fireproof Window Casing in Business Office	4/6/2005	1,823	365	5	365		1,185	5
6	Therapy Room Painting	7/7/2005	500	100	5	100		300	6
7	Therapy Room Improvements	7/4/2005	1,098	110	10	110		330	7
8	Mural Painting In Therapy Gym	9/15/2005	3,000	600	5	600		1,700	8
9	Therapy Area New Flooring	7/11/2005	3,460	692	5	692		2,076	9
10	Window For 300 Wing Day Room	1/1/2006	750	75	10	75		187	10
11	Roof Repairs Over 300 Hall	11/30/2005	11,800	1,180	10	1,180		3,147	11
12	(14) GE Zoneline AC Units For 300	4/13/2006	15,400	3,080	5	3,080		6,930	12
13	Parking Lot South Side of Bldg	6/26/2006	15,350	1,023	15	1,023		2,130	13
14	Sidewalk Between Nursing Home	4/13/2006	3,795	380	10	380		854	14
15	Rock & Delivery For Parking Lot On N	11/14/2005	878	176	5	176		468	15
16	5 ton, 3 phase compressor	9/29/2006	1,981	660	3	660		1,210	16
17	Front door and 300 hall SE door	12/29/2006	3,794	253	15	253		400	17
18	Install Laundry RTU & 30x20	8/8/2006	6,113	611	10	611		1,171	18
19	Install new floor in dining room	1/9/2007	3,155	631	5	631		946	19
20	Additions to fire alarm system	12/14/2006	1,235	247	5	247		391	20
21	Install tile flooring Nurses Station	2/1/2007	5,752	288	20	288		408	21
22	Install tile flooring Nurses Station	3/1/2007	1,355	68	20	68		91	22
23	Carpet and Vinyl floorcovering	3/1/2007	1,925	385	5	385		513	23
24	New Vinyl Flooring- Alzheimers	6/27/2007	787	158	5	158		171	24
25	Bulletin Boards and Memo Boards	7/19/2007	2,386	239	10	239		239	25
26	Wire Glass Frames windows	8/22/2007	2,440	224	10	224		224	26
27	81 Gallon Commercial hot water heater	9/14/2007	5,261	438	10	438		438	27
28	Shelter behind Nursing Home	11/8/2007	884	59	10	59		59	28
29	New Lever locks in kitchen	2/13/2008	1,099	46	10	46		46	29
30	Kitchen Flooring	3/21/2008	19,500	650	10	650		650	30
31	Add & Move Fire Alarms	3/31/2008	3,336	111	10	111		111	31
32	Photo Detector & Sensor	3/31/2008	762	25	10	25		25	32
33	Saniglaze for shower rooms	4/30/2008	1,030	26	10	26		26	33
34	TOTAL (lines 1 thru 33)		\$ 4,514,761	\$ 133,824		\$ 135,375	\$ 1,551	\$ 2,353,867	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,514,761	\$ 133,824		\$ 135,375	\$ 1,551	\$ 2,353,867	1
2	Kitchen Project	5/23/2008	680	11	10	11		11	2
3	Kitchen Remodeling Project - Sink	5/31/2008	3,457	58	10	58		58	3
4	Install new 100 Wing exit door	6/20/2008	18,396	153	10	153		153	4
5	Kitchen Remodeling Project-	6/30/2008	4,821	40	10	40		40	5
6	Window in NH Chapel Area	6/20/2008	614	5	10	5		5	6
7	Flooring - 100 wing exit door	6/20/2008	788	13	5	13		13	7
8	Restore & Reseal tile floor - lobby	6/30/2008	900	8	10	8		8	8
9	Air Spa bathing system	6/30/2008	12,492	104	10	104		104	9
10	Sidewalk	4/30/2008	2,266	57	10	57		57	10
11	Paving, extended parking lots, 2 new exits	5/10/2008	30,273	505	10	505		505	11
12	Handrails outside of building	5/30/2008	17,013	284	10	284		284	12
13	white vinyl fencing	6/19/2008	3,580	30	10	30		30	13
14	landscaping - plants, shrubs	6/25/2008	903	8	10	8		8	14
15	sidewalk & ramp to 100 wing exit door	6/20/2008	817	7	10	7		7	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,611,761	\$ 135,107		\$ 136,658	\$ 1,551	\$ 2,355,150	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, 2007 Ending: June 30, 2008

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	\$ 628,672	\$ 71,145	\$ 71,145	\$	Various	\$ 407,385	71
72	Current Year Purchases	62,646	4,086	4,086		Various	4,086	72
73	Fully Depreciated Assets	408,998				Various	408,998	73
74	Home Office Allocation	128,565	9,003	9,003			20,210	74
75	TOTALS	\$ 1,228,881	\$ 84,234	\$ 84,234	\$		\$ 840,679	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	1192 Bus & Chevy Van w/ lift	2/27/1992	\$ 47,260	\$	\$	\$	3	\$ 47,260	76
77	Non Patient Transportation	1999 Ford Ranger	4/11/2006	4,800	1,600	1,600		3	3,600	77
78	Non Patient Transportation	5' x 14' Tandem Axel Trailer	4/11/2006	900	113	113		8	226	78
79	Home Office Allocation			14,212	995	995			5,405	79
80	TOTALS			\$ 67,172	\$ 2,708	\$ 2,708	\$		\$ 56,491	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)	\$ 5,996,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,049	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 223,600	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,551	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,252,320	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	\$ 460,925	\$ 13,999	\$ 390,055	86
87	Congregate	2,156,257	60,747	1,299,882	87
88	Duplex	1,794,797	47,662	1,026,984	88
89	Land	230,405			89
90					90
91	TOTALS	\$ 4,642,384	\$ 122,408	\$ 2,716,921	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocations	\$ 4,968	92
93			93
94			94
95		\$ 4,968	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, 2007

Ending: June 30, 2008

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 22,857 Description: See Attached Detailed Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.

Facility Name & ID Number Christian Nursing Home# 0004630 Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	\$	4,351	\$ 288,936	\$	4,351	\$ 288,936	1
2	Licensed Speech and Language Development Therapist		hrs		926	82,776		926	82,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,147	333,781		5,147	333,781	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,424	\$ 705,493	\$	10,424	\$ 705,493	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, 2007 Ending: June 30, 2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,935,273	\$	1
2	Cash-Patient Deposits	10,983		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (32,835))	668,613		3
4	Supply Inventory (priced at)	24,471		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,501		6
7	Other Prepaid Expenses	8,838		7
8	Accounts Receivable (owners or related parties)	342,314		8
9	Other(specify): <u>Accrued Interest Rec.</u>	3,080		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,996,073	\$	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	8,431,877		14
15	Leasehold Improvements, at Historical Cost	288,252		15
16	Equipment, at Historical Cost	1,413,091		16
17	Accumulated Depreciation (book methods)	(5,809,515)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,863,211		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,501,286	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,497,359	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 159,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,983		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	297,722		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,124		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>	13,430		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 482,421	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,208,256		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Apartment Income</u>	809,914		43
44	<u>Apt & Cong Life Right & Sec</u>	670,556		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,688,726	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,171,147	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,326,212	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,497,359	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,323,044	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,323,044	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,003,168	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)	\$ 1,003,168	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,326,212	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2007Ending: June 30, 2008**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	\$ 5,971,630	1
2	Discounts and Allowances for all Levels	(580,862)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,390,768	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,046,410	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,046,410	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	27,800	13
14	Non-Patient Meals	1,971	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,298	16
17	Sale of Drugs	3,835	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,627	19
20	Radiology and X-Ray	16,277	20
21	Other Medical Services	(664)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 96,144	23
D. Non-Operating Revenue			
24	Contributions	133,358	24
25	Interest and Other Investment Income***	94,398	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 227,756	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized Gain (Loss) on Investments	(160,554)	28
28a	Residential / Congregate	839,547	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 678,993	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,440,071	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,009,684	31
32	Health Care	3,065,452	32
33	General Administration	1,402,235	33
B. Capital Expense			
34	Ownership	308,709	34
C. Ancillary Expense			
35	Special Cost Centers	589,335	35
36	Provider Participation Fee	61,488	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,436,903	40
41	Income before Income Taxes (line 30 minus line 40)**	1,003,168	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,003,168	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, 2007

Ending:

June 30, 2008

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	1,763	1,918	\$ 88,160	\$ 45.96	1
2	Assistant Director of Nursing	1,799	1,994	48,446	24.30	2
3	Registered Nurses	5,004	6,087	138,391	22.74	3
4	Licensed Practical Nurses	27,029	30,326	543,261	17.91	4
5	CNAs & Orderlies	67,741	76,570	814,488	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,791	5,462	66,518	12.18	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	16,431	18,108	199,156	11.00	11
12	Dietician					12
13	Food Service Supervisor	1,671	1,968	35,672	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,064	18,921	161,243	8.52	15
16	Dishwashers					16
17	Maintenance Workers	6,620	6,970	90,583	13.00	17
18	Housekeepers	18,705	21,116	176,918	8.38	18
19	Laundry					19
20	Administrator	1,610	1,910	153,374	80.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,587	2,030	34,484	16.99	23
24	Clerical	3,484	4,033	52,524	13.02	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 <u>ward clerk</u>	2,022	2,201	29,578	13.44	32
33	Other(specify) <u>Marketing, CNL, V</u>	7,427	8,168	201,939	24.72	33
34	TOTAL (lines 1 - 33)	184,748	207,782	\$ 2,834,735 *	\$ 13.64	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	207	\$ 10,133	1-3	35
36	Medical Director	6	3,150	9-3	36
37	Medical Records Consultant	16	2,775	10-3	37
38	Nurse Consultant	60	6,650	10-3	38
39	Pharmacist Consultant	8	3,305	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	77	4,236	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	374	\$ 30,249		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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Charlotte Bennett</u>	<u>Administrator</u>		\$ <u>153,374</u>	<u>Workers' Compensation Insurance</u>	\$ <u>119,532</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>5,178</u>	<u>Advertising: Employee Recruitment</u>	<u>29,580</u>	
				<u>FICA Taxes</u>	<u>209,776</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>97,170</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses & Dues</u>	<u>12,536</u>	
				<u>W C Medical Exp</u>	<u>203</u>	<u>Subscriptions</u>	<u>3,062</u>	
				<u>Employee Physicals</u>	<u>4,250</u>	<u>Remote Fee & Support</u>	<u>(13)</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>153,374</u>			<u>Other</u>	<u>44</u>	
(List each licensed administrator separately.)						<u>Advertising & Promotion</u>	<u>16,731</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Expense</u>			\$ <u>363,300</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	<u>5,955</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>363,300</u>				<u>Seminar Expense</u>	<u>3,046</u>
(Attach a copy of any management service agreement)							<u>Home Office Allocation</u>	<u>14,268</u>
C. Professional Services								
Vendor/Payee	Type		Amount				<u>Entertainment Expense</u>	()
<u>Davis & Campbell LLC</u>	<u>Legal</u>		\$ <u>2,846</u>				(agree to Sch. V,	
<u>Gauis G. Nelson Architects</u>	<u>Architects</u>		<u>9,180</u>				line 24, col. 8)	
<u>Elvidge Kelley</u>	<u>Legal</u>		<u>1,033</u>				TOTAL	\$ <u>23,269</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>13,059</u>	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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. \$6,957 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. \$ 14,241 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,488
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. \$ 1,971
- (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? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.