

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0004630</u></p> <p>Facility Name: <u>Christian Nursing Home</u></p> <p>Address: <u>1507 7th Street</u> <u>Lincoln</u> <u>62656</u> Number City Zip Code</p> <p>County: <u>Logan</u></p> <p>Telephone Number: <u>217-732-2189</u> Fax # <u>217-732-1904</u></p> <p>HFS ID Number: <u>37-0841562004</u></p> <p>Date of Initial License for Current Owners: <u>09/01/1965</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Susan McGhee</u> Telephone Number: <u>217-732-5175</u> Email Address: _____</p>	<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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2008</u> to <u>June 30, 2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Tim Phillippe</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr, Ste 100, St. Louis, MO 63131</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</u></td> <td></td> </tr> </table> <p>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</p>	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 Dr, Ste 100, St. Louis, MO 63131</u>		(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</u>	
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Facility Name & ID Number Christian Nursing Home

0004630 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>112</u>	TOTALS	<u>112</u>	<u>40,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	<u>15,687</u>	<u>15,411</u>	<u>5,728</u>	<u>36,826</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>15,687</u>	<u>15,411</u>	<u>5,728</u>	<u>36,826</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.08%

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 residents

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 5,362

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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	213,218	38,821	8,932	260,971		260,971		260,971		1
2	Food Purchase		252,091		252,091		252,091	(2,885)	249,206		2
3	Housekeeping	183,761	36,905	1,802	222,468		222,468		222,468		3
4	Laundry			5,386	5,386		5,386		5,386		4
5	Heat and Other Utilities			181,125	181,125		181,125	7,899	189,024		5
6	Maintenance	92,918	14,800	67,505	175,223		175,223	2,270	177,493		6
7	Other (specify):* Trash			2,818	2,818		2,818		2,818		7
8	TOTAL General Services	489,897	342,617	267,568	1,100,082		1,100,082	7,284	1,107,366		8
	B. Health Care and Programs										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	2,061,811	353,736	87,698	2,503,245	(164,760)	2,338,485		2,338,485		10
10a	Therapy		1,062	662,975	664,037		664,037		664,037		10a
11	Activities	103,140			103,140		103,140	(2)	103,138		11
12	Social Services	83,705	4,194	17,761	105,660		105,660		105,660		12
13	CNA Training										13
14	Program Transportation			4,914	4,914		4,914	(3,161)	1,753		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,248,656	358,992	775,148	3,382,796	(164,760)	3,218,036	(3,163)	3,214,873		16
	C. General Administration										
17	Administrative	145,616	1,510	400,979	548,105		548,105	(328,114)	219,991		17
18	Directors Fees										18
19	Professional Services			9,300	9,300		9,300	27,489	36,789		19
20	Dues, Fees, Subscriptions & Promotions			74,899	74,899		74,899	(235)	74,664		20
21	Clerical & General Office Expenses	93,638	7,689	47,374	148,701		148,701	167,027	315,728		21
22	Employee Benefits & Payroll Taxes			499,365	499,365		499,365	25,445	524,810		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,221	16,221		16,221	11,695	27,916		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			89,886	89,886		89,886	1,368	91,254		26
27	Other (specify):* Marketing	54,207	1,499	14,388	70,094		70,094	(70,094)			27
28	TOTAL General Administration	293,461	10,698	1,152,412	1,456,571		1,456,571	(165,419)	1,291,152		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,032,014	712,307	2,195,128	5,939,449	(164,760)	5,774,689	(161,298)	5,613,391		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, 2008

Ending:

June 30, 2009

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			221,664	221,664		221,664	16,028	237,692			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,152	69,152		69,152	(9,699)	59,453			32
33	Real Estate Taxes			1,224	1,224		1,224	(1,224)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			43,557	43,557		43,557		43,557			35
36	Other (specify):* Financing Fees			1,632	1,632		1,632		1,632			36
37	TOTAL Ownership			337,229	337,229		337,229	5,105	342,334			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			65,449	65,449	164,760	230,209		230,209			39
40	Barber and Beauty Shops			28,553	28,553		28,553		28,553			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			516,137	516,137		516,137	(516,137)				43
44	TOTAL Special Cost Centers			671,459	671,459	164,760	836,219	(516,137)	320,082			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,032,014	712,307	3,203,816	6,948,137		6,948,137	(672,330)	6,275,807			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,675)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,301)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,429)	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	4,487	21		24
25	Fund Raising, Advertising and Promotional	(70,094)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(524,651)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (605,663)		\$	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)	(66,667)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,667)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (672,330)		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		164,760	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 164,760	47

BHF USE ONLY							
48		49		50		51	52

Christian Nursing Home

ID# 0004630

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (210)	2	1
2	Activity	(2)	11	2
3	Transportation	(3,161)	14	3
4	Apt / Congregate	(516,137)	43	4
5	RE Tax on Vacant Lots	(1,224)	33	5
6	Yellow Page Advertising	(235)	20	6
7	Charity Care	(3,682)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	(524,651)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,885)	0	0	0	0	0	0	0	0	0	0	(2,885)	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	(1,301)	9,200	0	0	0	0	0	0	0	0	0	7,899	5
6	Maintenance	0	2,270	0	0	0	0	0	0	0	0	0	2,270	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,186)	11,470	0	7,284	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	(2)	0	0	0	0	0	0	0	0	0	0	(2)	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	(3,161)	0	0	0	0	0	0	0	0	0	0	(3,161)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,163)	0	0	0	0	0	0	0	0	0	0	(3,163)	16
	C. General Administration													
17	Administrative	0	(328,114)	0	0	0	0	0	0	0	0	0	(328,114)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,489	0	0	0	0	0	0	0	0	0	27,489	19
20	Fees, Subscriptions & Promotions	(235)	0	0	0	0	0	0	0	0	0	0	(235)	20
21	Clerical & General Office Expenses	805	166,222	0	0	0	0	0	0	0	0	0	167,027	21
22	Employee Benefits & Payroll Taxes	0	25,445	0	0	0	0	0	0	0	0	0	25,445	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,695	0	0	0	0	0	0	0	0	0	11,695	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	1,368	0	0	0	0	0	0	0	0	0	1,368	26
27	Other (specify):*	(70,094)	0	0	0	0	0	0	0	0	0	0	(70,094)	27
28	TOTAL General Administration	(69,524)	(95,895)	0	(165,419)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,873)	(84,425)	0	(161,298)	29								

STATE OF ILLINOIS

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

July 1, 2008 Ending:

Summary B

June 30, 2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	16,028	0	0	0	0	0	0	0	0	0	16,028	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,429)	1,730	0	0	0	0	0	0	0	0	0	(9,699)	32
33	Real Estate Taxes	(1,224)	0	0	0	0	0	0	0	0	0	0	(1,224)	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	(12,653)	17,758	0	5,105	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):*	(516,137)	0	0	0	0	0	0	0	0	0	0	(516,137)	43
44	TOTAL Special Cost Centers	(516,137)	0	0	0	0	0	0	0	0	0	0	(516,137)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(605,663)	(66,667)	0	(672,330)	45								

Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 9,200	\$ 9,200	1
2	V	6 Maintenance				2,270	2,270	2
3	V	17 Administration	387,660			59,546	(328,114)	3
4	V	19 Professional Services				27,489	27,489	4
5	V	21 Clerical				166,222	166,222	5
6	V	22 Employee Benefits				25,445	25,445	6
7	V	24 Travel & Seminar				11,695	11,695	7
8	V	26 Insurance				1,368	1,368	8
9	V	30 Depreciation				16,028	16,028	9
10	V	32 Interest				1,730	1,730	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 387,660			\$ 320,993	\$ * (66,667)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	This workpaper is not applicable										1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13							TOTAL	\$			13

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

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

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2008

Ending: ne 30, 2009

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

Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2008 Ending:

June 30, 2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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	0.0567	\$ 21,451	1					
2	Bond Fund	X		Debt Restructure	\$2,125.00	Various*	1,025,000	796,392	6/30/2032	Various*	47,701	2					
3	*this is an allocation of the total GO bond debt which includes several different series with several different rates of interest																
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$2,125.00		\$ 1,407,171	\$ 1,178,563			\$ 69,152	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	\$ 1,178,563			\$ 69,152	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(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>See Attached</u>	\$ <u>889.00</u>	\$ _____
2.	<u>12-623-005-00</u>	<u>See Attached</u>	\$ <u>302.00</u>	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>1,191.00</u>	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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, 2008 Ending:

June 30, 2009

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 Use	2 Square Feet	3 Year Acquired	4 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>4,927</u>	<u>2</u>
3	TOTALS	42,000		\$ 88,892	3

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	\$ 5,039		\$ 259,943	4
5	26		1969	1969	282,500	5,650	50	5,650		270,919	5
6	26		1972	1972	318,878	6,785	47	6,785		306,334	6
7	12			2000	1,279,292	31,834	40	31,834		279,548	7
8	Home Office Allocation				46,803	3,427		3,427		88,154	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		8,003	12
13	Windows & Improvements			1980	36,891	1,054	35	1,054		31,620	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		3,563	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											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		17,257	31
32	Windows			1985	7,800	223	35	223		5,352	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		7,645	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, 2008 Ending: June 30, 2009

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		20			2,396	58
59	Lights	1987	364		10			364	59
60	Metal Door	1987	440		20			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	156	20	156		6,066	63
64	A/C System	1989	42,748	1,254	20	1,254		42,748	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		657	67
68	Condensing Unit	1989	700		5			700	68
69	Sprinkler System	1989	4,106	205	20	205		4,067	69
70	TOTAL (lines 4 thru 69)		\$ 2,706,885	\$ 57,100		\$ 57,100	\$	\$ 1,544,493	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, 2008 Ending: June 30, 2009

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		\$ 2,706,885	\$ 57,100		\$ 57,100	\$	\$ 1,544,493	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		383	6
7	Doors	1990	508	25	20	25		474	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		373	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		21,789	21
22	Life Safety	1992	814		20			814	22
23	Doors (5)	1992	2,550	128	20	128		2,207	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		1,070	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		1,184	26
27	Life Safety	1992	973		20			973	27
28	Furnaces	1992	13,165	658	20	658		11,023	28
29	Wall Paper	1992	3,376		5			3,376	29
30	Lighting	1993	954		10			954	30
31	Air Conditioner	1993	4,475		10			4,475	31
32	Reroof	1993	8,477	385	22	385		6,202	32
33	SW Roof	1993	900	41	22	41		649	33
34	TOTAL (lines 1 thru 33)		\$ 2,823,440	\$ 59,759		\$ 59,759	\$	\$ 1,651,737	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, 2008 Ending: June 30, 2009

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		\$ 2,823,440	\$ 59,759		\$ 59,759	\$	\$ 1,651,737	1
2	Furnaces	1993	4,570	229	20	229		3,358	2
3	Lighting Life Safety	1994	973		10			973	3
4	Panels/Base Dayroom	1994	860		5			860	4
5	Drive Up/Curb Canopy	1994	7,108		10			7,108	5
6	Door Alarms	1994	851		5			851	6
7	Doors	1994	1,319		10			1,319	7
8	Front Entrance	1995	11,006		10			11,006	8
9	Roof	1995	6,300		5			6,300	9
10	Roof	1995	15,582		10			15,582	10
11	Front Entrance	1996	7,125		10			7,125	11
12	Roof Work	1996	3,400		5			3,400	12
13	Cnds. Unit-100	1996	2,742		10			2,742	13
14	Roof Work	1996	536		5			536	14
15	Roof Work Ewing	1996	3,062		5			3,062	15
16	Roof Repairs	1996	1,279		5			1,279	16
17	Lights & Dampers	1997	17,712		10			17,712	17
18	Courtyard Door	1997	972		10			972	18
19	Office Roof Work	1997	2,275		5			2,275	19
20	Roof Work 100 Wing	1997	13,120		10			13,120	20
21	Floor Covering	1997	2,091		5			2,091	21
22	Roof Work N&S Wing	1998	12,500		10			12,500	22
23	South Wing Roof Work	1998	14,800		10			14,800	23
24	A/C in Lobby	1998	1,226		10			1,226	24
25	Compressor - Laundry	1998	1,914		3			1,914	25
26	Roof Work	1999	1,920		5			1,920	26
27	Roof Work - Valley Area	1999	5,073		5			5,073	27
28	Carpeting 300 Wing	1999	11,167		5			11,167	28
29	A/C Unit 300 Wing	1999	4,284	110	10	110		4,284	29
30	Roof Work Dining Area	1999	6,590		5			6,590	30
31	Wallpaper 300 Wing	1999	12,512		5			12,512	31
32	Carpet Conference	1999	978		5			978	32
33	Carpet Lobby	1999	5,021		5			5,021	33
34	TOTAL (lines 1 thru 33)		\$ 3,004,308	\$ 60,098		\$ 60,098	\$	\$ 1,831,393	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, 2008 Ending: June 30, 2009

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		\$ 3,004,308	\$ 60,098		\$ 60,098	\$	\$ 1,831,393	1
2	Carpeting	1999	3,473		5			3,473	2
3	Office A/C Unit	1999	2,715	155	10	155		2,715	3
4	Carpeting	1999	1,743		5			1,743	4
5	Roof Work	1999	3,665		5			3,665	5
6	Remodel Beauty Shop	1999	1,339		5			1,339	6
7	Roof work	2000	5,536		5			5,536	7
8	Opto 22 energy management	2000	14,795	986	15	986		9,615	8
9	AD Smith water heater	2000	3,195	320	10	320		3,119	9
10	Water heater	2000	5,590	559	10	559		5,357	10
11	Handwash station	2000	1,140	76	15	76		422	11
12	Kitchen expansion	2000	790,605	19,765	40	19,765		184,473	12
13	Wallcover Staff DR	2000	933		5			933	13
14	Storage cabs	2000	676	45	15	45		420	14
15	Condensing unit	2000	2,530	169	15	169		1,548	15
16	Compressor laundry	2000	1,524	127	12	127		1,164	16
17	Heaters in Dayroom	2000	1,029	69	15	69		597	17
18	Wallpaper Secretary Office	2001	2,943		5			2,943	18
19	Alzheimbers Addition	2000	90,006	2,250	40	2,250		19,688	19
20	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		22,052	20
21	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		4,208	21
22	12 SMOKE DETECTORS	2001	1,504	150	10	150		1,251	22
23	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		1,293	23
24	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		560	24
25	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		455	25
26	Compressors Etc, 300 Wing	2001	1,732		3			1,732	26
27	3 Swinging Fire Doors W/ Frames	2001	12,304	1,230	10	1,230		9,534	27
28	Main Breaker - NH	2001	4,718	472	10	472		3,619	28
29	Vinyl For Various Ares	2001	8,528		5			8,528	29
30	Carpeting - Activity Room	2001	15,290		5			15,290	30
31	Floor Coverings - 100/200 Wings	2002	28,850		5			28,850	31
32	Roof Repairs	2002	2,211	221	10	221		1,602	32
33	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		3,113	33
34	TOTAL (lines 1 thru 33)		\$ 4,052,046	\$ 90,609		\$ 90,609	\$	\$ 2,182,230	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, 2008 Ending: June 30, 2009

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,052,046	\$ 90,609		\$ 90,609	\$	\$ 2,182,230	1
2	(2) Hot water holding tanks	11/18/2002	9,434	629	15	629		4,193	2
3	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	510	10	510		3,188	3
4	Carpet/Wallpaper - Administrators Office	5/28/2003	2,555		5			2,555	4
5	Roof Repairs - 200 Hall	6/9/2003	4,600	460	10	460		2,798	5
6	10 x12 Storage shed	6/10/1999	1,578	143	10	143		1,578	6
7	Fully depreciated land improvements	6/30/1975	104,624		20			104,624	7
8	Landscaping and plants	5/23/1989	686	33	20	33		686	8
9	Survey and land clearing	5/7/1992	3,350	168	20	168		2,875	9
10	Fence, garbage area	9/30/1992	542		10			542	10
11	Landscaping entrance	5/4/1995	1,273		10			1,273	11
12	Landscaping, patio, water, lights	8/21/2000	30,266	3,026	10	3,026		26,818	12
13	Shuffleboard court	6/1/2003	785		5			785	13
14	Wallpaper 100/200 Wing - Dining Room	1/29/2004	12,387	1,239	5	1,239		12,387	14
15	Roof repair/Rehab/Nurs Stat/Day Room	10/22/2003	46,500	4,650	10	4,650		26,738	15
16	High Efficiency Ballasts/Lights	11/25/2003	15,076	1,508	10	1,508		8,544	16
17	Office Telephone System	1/15/2004	8,146	815	5	815		8,146	17
18	Business Office - Sound Proofing	12/1/2003	1,506	151	10	151		842	18
19	PT Room Renovation	1/31/2004	4,407	441	5	441		4,407	19
20	Conference Room Remodeling	1/31/2004	846	85	5	85		846	20
21	Smoke Detectors - Telephone & OT Office	3/25/2004	1,333	133	10	133		710	21
22	Network Cabling	2/16/2004	6,825	683	10	683		3,699	22
23	Smoke Detectors - Resident Rooms	4/14/2004	3,707	371	10	371		1,947	23
24	(20) Smoke alarms in Nursing home	4/20/2004	1,617	162	10	162		850	24
25	Computer Upgrade on Energy Mgmt System	4/14/2004	6,000	600	10	600		3,150	25
26	Roof Repairs - 400 Wing	6/14/2004	4,500	450	10	450		2,288	26
27									27
28	3 Ton A/C for Laundry	6/30/2004	2,386	239	10	239		1,214	28
29	A/C Unit - 100 Hall	6/30/2004	1,231	123	10	123		625	29
30	(4) Call Cord Stations	10/20/2004	770	154	5	154		732	30
31	Remodel Front Entrance/Business Office	10/1/2004	11,056	2,211	5	2,211		10,502	31
32	Install Dampers/Misc Energy Mgmt Work	3/11/2005	1,434		3			1,434	32
33	Roof Repairs	3/29/2005	33,088	3,309	10	3,309		14,339	33
34	TOTAL (lines 1 thru 33)		\$ 4,379,654	\$ 112,902		\$ 112,902	\$	\$ 2,437,545	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, 2008 Ending: June 30, 2009

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		\$ 4,379,654	\$ 112,902		\$ 112,902	\$	\$ 2,437,545	1
2	Add'l Smoke Detectors (Life Safety)	3/25/2005	1,585	159	10	159		688	2
3	Generator Upgrade (Life Safety)	4/1/2005	2,621	262	10	262		1,114	3
4	Fireproof Window Casing in Business Office	4/6/2005	1,823	365	5	365		1,550	4
5	Therapy Room Painting	7/7/2005	500	100	5	100		400	5
6	Therapy Room Improvements	7/4/2005	1,098	110	10	110		440	6
7	Mural Painting In Therapy Gym	9/15/2005	3,000	600	5	600		2,300	7
8	Therapy Area New Flooring	7/11/2005	3,460	692	5	692		2,768	8
9	Window For 300 Wing Day Room	1/1/2006	750	75	10	75		262	9
10	Roof Repairs Over 300 Hall	11/30/2005	11,800	1,180	10	1,180		4,327	10
11	(14) GE Zoneline AC Units For 300	4/13/2006	15,400	3,080	5	3,080		10,010	11
12	Parking Lot South Side of Bldg	6/26/2006	15,350	1,023	15	1,023		3,153	12
13	Sidewalk Between Nursing Home	4/13/2006	3,795	380	10	380		1,234	13
14	Rock & Delivery For Parking Lot On N	11/14/2005	878	176	5	176		644	14
15	5 ton, 3 phase compressor	9/29/2006	1,981	660	3	660		1,870	15
16	Front foer and 300 hall SE door	12/29/2006	3,794	253	15	253		653	16
17	Install Laundry RTU & 30x20	8/8/2006	6,113	611	10	611		1,782	17
18	Install new floor in dining room	1/9/2007	3,155	631	5	631		1,577	18
19	Additions to fire alarm system	12/14/2006	1,235	247	5	247		638	19
20	Install tile flooring Nurses Station	2/1/2007	5,752	288	20	288		696	20
21	Install tile flooring Nurses Station	3/1/2007	1,355	68	20	68		159	21
22	Carpet and Vinyl floorcovering	3/1/2007	1,925	385	5	385		898	22
23	New Vinyl Flooring- Alzheimers	6/27/2007	787	158	5	158		329	23
24	Bulletin Boards and Memo Boards	7/19/2007	2,386	239	10	239		478	24
25	Wire Glass Frames windows	8/22/2007	2,440	244	10	244		468	25
26	81 Gallon Commercial hot water heater	9/14/2007	5,261	526	10	526		964	26
27	Shelter behind Nursing Home	11/8/2007	884	88	10	88		147	27
28	New Lever locks in kitchen	2/13/2008	1,099	110	10	110		156	28
29	Kitchen Flooring	3/21/2008	19,500	1,950	10	1,950		2,600	29
30	Add & Move Fire Alarms	3/31/2008	3,336	334	10	334		445	30
31	Photo Detector & Sensor	3/31/2008	762	76	10	76		101	31
32	Saniglaze for shower rooms	4/30/2008	1,030	103	10	103		129	32
33	Kitchen Project	5/23/2008	680	68	10	68		79	33
34	TOTAL (lines 1 thru 33)		\$ 4,505,189	\$ 128,143		\$ 128,143	\$	\$ 2,480,604	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, 2008 Ending: June 30, 2009

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		\$ 4,505,189	\$ 128,143		\$ 128,143	\$	\$ 2,480,604	1
2	Kitchen Remodeling Project - Sink	5/31/2008	3,457	346	10	346		404	2
3	Install new 100 Wing exit door	6/20/2008	18,396	1,840	10	1,840		1,993	3
4	Kitchen Remodeling Project-	6/30/2008	4,821	482	10	482		522	4
5	Window in NH Chapel Area	6/20/2008	614	61	10	61		66	5
6	Flooring - 100 wing exit door	6/20/2008	788	158	5	158		171	6
7	Restore & Reseal tile floor - lobby	6/30/2008	900	90	10	90		98	7
8	Air Spa bathing system	6/30/2008	12,492	1,249	10	1,249		1,353	8
9	Sidewalk	4/30/2008	2,266	227	10	227		284	9
10	Paving, extended parking lots, 2 new exits	5/10/2008	30,273	3,027	10	3,027		3,532	10
11	Handrails outside of building	5/30/2008	17,013	1,701	10	1,701		1,985	11
12	white vinyl fencing	6/19/2008	3,580	358	10	358		388	12
13	landscaping - plants, shrubs	6/25/2008	903	90	10	90		98	13
14	sidewalk & ramp to 100 wing exit door	6/20/2008	817	82	10	82		89	14
15	Roofing - shingles and labor	7/22/2008	21,000	2,100	10	2,100		2,100	15
16	Glass sliding door - Dayroom	8/27/2008	2,500	229	10	229		229	16
17	Patio cover	9/18/2008	1,195	100	10	100		100	17
18	Plank flooring	9/8/2008	7,268	606	10	606		606	18
19	Roof	9/20/2008	3,410	284	10	284		284	19
20	Painting - Activity Room	11/14/2008	700	93	5	93		93	20
21	Hot water boiler & installation	2/27/2009	10,748	448	10	448		448	21
22	Sterling 60,000 heater	3/6/2009	885	30	10	30		30	22
23	4 Simplex locks	4/13/2009	2,200	55	10	55		55	23
24	Accutech Resident Security System	4/28/2009	58,975	1,474	10	1,474		1,474	24
25	Sprinkler Project - Architect	6/1/2009	1,503	13	10	13		13	25
26	Rooftop A/C units	6/19/2009	5,500	46	10	46		46	26
27	2 A/C Rooftop units	6/23/2009	16,000	133	10	133		133	27
28	A/C coil - 100 hallway	6/19/2009	3,542	59	5	59		59	28
29	Landscaping - front entrance, main building	7/28/2008	2,062	206	10	206		206	29
30	Landscaping - flag pole and Alzheimer's area	7/28/2008	1,214	121	10	121		121	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,740,211	\$ 143,851		\$ 143,851	\$	\$ 2,497,584	34

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

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	\$ 662,985	\$ 68,925	\$ 68,925	\$	Various	\$ 391,165	71
72	Current Year Purchases	136,970	7,820	7,820		Various	7,820	72
73	Fully Depreciated Assets	419,786	3,440	3,440		Various	419,786	73
74	Home Office Allocation	154,210	11,292	11,292			22,858	74
75	TOTALS	\$ 1,373,951	\$ 91,477	\$ 91,477	\$		\$ 841,629	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	2009 Ford Starcraft Bus	6/1/2009	\$ 56,722	\$ 503	\$ 503	\$	8	\$ 503	76
77	Patient Transportation	2000 Chevy Van Lift	9/9/2003	8,432				3	8,432	77
78	Patient Transportation	2009 Tomberlin E4 Golf Cart	4/10/2009	8,850	553	553		4	553	78
79	Home Office Allocation			17,861	1,308	1,308			7,959	79
80	TOTALS			\$ 91,865	\$ 2,364	\$ 2,364	\$		\$ 17,447	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)	\$ 6,294,919	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 237,692	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 237,692	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,356,660	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Ford Ranger - 4/11/06	\$ 4,800	\$ 1,200	\$ 4,800	86
87	5' x 14' Tandem Axel Trailer - 4/11/06	900	113	338	87
88	Land	230,405			88
89	Apartment/Congregate	2,631,298	73,485	1,759,765	89
90	Duplex	1,805,373	47,784	1,073,562	90
91	TOTALS	\$ 4,672,776	\$ 122,582	\$ 2,838,465	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 4,561	92
93			93
94			94
95		\$ 4,561	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, 2008

Ending: June 30, 2009

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

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: \$ 43,557 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

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>Training is done at local high school and hospital</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	10A-3	hrs	\$	4,107	\$ 287,043	\$	4,107	\$ 287,043	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		875	76,193		875	76,193	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		4,409	299,739		4,409	299,739	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,391	\$ 662,975	\$	9,391	\$ 662,975	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# 0004630Report Period Beginning: July 1, 2008Ending: June 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2009 (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	\$ 5,242,335	\$	1
2	Cash-Patient Deposits	12,356		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>26,624</u>)	578,680		3
4	Supply Inventory (priced at)	17,211		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,250		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	1,479		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,873,311	\$	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	8,572,204		14
15	Leasehold Improvements, at Historical Cost	291,528		15
16	Equipment, at Historical Cost	1,557,360		16
17	Accumulated Depreciation (book methods)	(6,077,324)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,733,754		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,391,892	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,265,203	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 216,989	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,356		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	351,645		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	595		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>	112,964		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 694,549	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,178,563		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Apartment Income</u>	770,375		43
44	<u>Apt & Cong Life Right & Sec</u>	682,242		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,631,180	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,325,729	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,939,474	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,265,203	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,326,212	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,326,212	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	613,262	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)	\$ 613,262	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)	\$ 8,939,474	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2008Ending: June 30, 2009

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	\$ 6,274,675	1
2	Discounts and Allowances for all Levels	(1,116,184)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,158,491	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,474,420	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,474,420	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	28,364	13
14	Non-Patient Meals	2,675	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,301	16
17	Sale of Drugs	6,998	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,731	19
20	Radiology and X-Ray	20,205	20
21	Other Medical Services	56,445	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 159,719	23
D. Non-Operating Revenue			
24	Contributions	140,345	24
25	Interest and Other Investment Income***	44,401	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 184,746	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized and Realized Gain (Loss) on Investments	(153,369)	28
28a	Residential / Congregate	737,392	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 584,023	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,561,399	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,100,082	31
32	Health Care	3,382,796	32
33	General Administration	1,456,571	33
B. Capital Expense			
34	Ownership	337,229	34
C. Ancillary Expense			
35	Special Cost Centers	610,139	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)*	\$ 6,948,137	40
41	Income before Income Taxes (line 30 minus line 40)**	613,262	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 613,262	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, 2008**

Ending:

June 30, 2009

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	1,337	1,374	\$ 59,323	\$ 43.18	1
2	Assistant Director of Nursing	2,217	2,239	60,955	27.22	2
3	Registered Nurses	6,911	8,293	270,202	32.58	3
4	Licensed Practical Nurses	25,238	28,359	518,776	18.29	4
5	CNAs & Orderlies	74,681	85,219	891,325	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,277	5,847	79,104	13.53	8
9	Activity Director	1,441	1,631	17,527	10.75	9
10	Activity Assistants	7,258	7,836	70,586	9.01	10
11	Social Service Workers	4,932	6,192	66,410	10.73	11
12	Dietician					12
13	Food Service Supervisor	1,796	1,931	39,545	20.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,732	19,620	173,674	8.85	15
16	Dishwashers					16
17	Maintenance Workers	6,460	6,969	92,918	13.33	17
18	Housekeepers	18,623	21,115	183,761	8.70	18
19	Laundry					19
20	Administrator	1,693	1,881	145,616	77.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,876	2,058	36,910	17.93	23
24	Clerical	3,443	3,900	52,253	13.40	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	2,021	2,201	70,618	32.08	32
33	Other(specify) <u>Marketing, CNL,</u>	7,427	8,168	202,511	24.79	33
34	TOTAL (lines 1 - 33)	190,363	214,833	\$ 3,032,014 *	\$ 14.11	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	181	\$ 8,932	1-3	35
36	Medical Director	6	1,800	9-3	36
37	Medical Records Consultant	16	4,839	10-3	37
38	Nurse Consultant	40	5,100	10-3	38
39	Pharmacist Consultant	168	3,323	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	83	4,617	12-3	45
46	Other(specify)				46
47	<u>Utilization Review Committee</u>	3	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	497	\$ 29,811		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	606	\$ 53,176	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	606	\$ 53,176		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Charlotte Bennett</u>	<u>Administrator</u>		\$ <u>145,616</u>	<u>Workers' Compensation Insurance</u>	\$ <u>63,262</u>	<u>IDPH License Fee</u>	\$ <u>45,188</u>	
				<u>Unemployment Compensation Insurance</u>	<u>14,323</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>228,064</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>161,930</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Food Sanitation Certificates</u>	<u>70</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>License</u>	<u>12,145</u>	
				<u>Employee Physicals</u>	<u>5,828</u>	<u>Dues</u>	<u>7,936</u>	
				<u>Employee Expense</u>	<u>24,866</u>	<u>Subscriptions</u>	<u>9,470</u>	
				<u>457 Plan Expense</u>	<u>1,000</u>	<u>Sponsorship Fee</u>	<u>90</u>	
				<u>Employee Uniforms</u>	<u>(384)</u>	<u>Less: Public Relations Expense</u>	(_____)	
				<u>Executive Retention Expense</u>	<u>476</u>	<u>Non-allowable advertising</u>	(_____)	
				<u>Home Office Allocation</u>	<u>25,445</u>	<u>Yellow page advertising</u>	<u>(235)</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>145,616</u>	TOTAL (agree to Schedule V,	\$ <u>524,810</u>	TOTAL (agree to Sch. V,	\$ <u>74,664</u>	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
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 Fee</u>			\$ <u>387,660</u>				<u>Out-of-State Travel</u>	\$ <u>1,683</u>
<u>Contracted Salaries - Dennis DeCosta, Interim Administrator</u>			<u>13,319</u>					
							<u>In-State Travel</u>	<u>8,587</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>400,979</u>				<u>Seminar Expense</u>	<u>5,951</u>
(Attach a copy of any management service agreement)							<u>Home Office Allocation</u>	<u>11,695</u>
C. Professional Services							<u>Entertainment Expense</u>	(_____)
Vendor/Payee	Type		Amount				TOTAL	(agree to Sch. V,
<u>Davis & Campbell</u>	<u>Legal</u>		\$ <u>5,922</u>				line 24, col. 8)	\$ <u>27,916</u>
<u>Elvidge Kelley</u>	<u>Legal</u>		<u>1,589</u>					
<u>Polsinelli/Shalton</u>	<u>Legal</u>		<u>200</u>					
<u>Thomas Van Hook</u>	<u>Legal</u>		<u>288</u>					
<u>My Inner View</u>	<u>Survey Services</u>		<u>1,301</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>9,300</u>	TOTAL		\$ _____		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2008 Ending: June 30, 2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$7,380
- (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. \$ 17,192 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. \$ 61,320
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. \$ 2,675
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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
- (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.